

**A STUDY OF THE EFFECTIVENESS OF CERTAIN OCCUPATIONAL
THERAPEUTIC GROUP TECHNIQUES IN THE ASSESSMENT OF THE
ACUTELY DISTURBED ADULT PSYCHIATRIC PATIENT**

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**A dissertation Submitted to the Faculty of Medicine
University of the Witwatersrand, Johannesburg
for the Degree of Master of Science (Occupational
Therapy)**

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ABSTRACT

A STUDY OF THE EFFECTIVENESS OF CERTAIN OCCUPATIONAL THERAPEUTIC GROUP TECHNIQUES IN THE ASSESSMENT OF THE ACUTELY DISTURBED ADULT PSYCHIATRIC PATIENT

**CROUCH, Rosemary Barncastle, B.Sc. (Occupational Therapy)
University of the Witwatersrand, 1983**

The research described in this dissertation proves that the occupational therapist, working closely with the acutely disturbed adult psychiatric patient during group-work, is able to make an assessment of aspects of the patient's psychopathology and functioning which does not differ significantly from the assessment made by other professional members of the psychiatric team over a longer period. This assessment made by the occupational therapist during one group session is a reliable contribution to the team evaluation of a patient.

There are two studies in the dissertation. Ten psychiatrists rated aspects of psychiatric assessment in terms of value towards the making of a diagnosis for a psychiatric patient. The "valuable" or "very valuable" aspects of assessment determined from this study were used in the assessment form in Study 2.

In Study 2 thirty acutely disturbed adult psychiatric patients were assessed. candidate during one hourly art and discussion groups. Only one group session was used to assess each patient. None of the patients had been assessed or in contact with the candidate previously. Each patient was also assessed by four other members of the psychiatric team, namely the Psychiatric Registrar, the Occupational Therapist

working with the patients in a permanent capacity, the Psychiatrically trained Nurse and the Social Worker, over the period of a week. The identical assessment form was completed by the candidate and the four assessors.

The five assessments have been compared by statistical analysis, namely the non-parametric Friedman test and the Hotelling T^2 test. Results indicate that no significant difference exists between the five assessments.

Conclusions indicate that the assessment made by the occupational therapist during art and discussion groups is reliable. Therefore the use of short-term group-work is an effective method of assessing the acutely disturbed, adult psychiatric patient.

DECLARATION

I declare that this dissertation, except for the statistical analysis of data, is my own unaided work.

The statistical analysis of data was carried out by Dr. S.G. Reinach and Professor H.H. Lemmer of the Institute for Biostatistics of the S.A. Medical Research Council.

The dissertation is being submitted for the degree of Master of Science (Occupational Therapy) in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other University.

Rosemary B. Crouch

1st day of February, 1984

To my dear family, Michael, Catherine, Susan and Liza

PREFACE

Many years of working in the psychiatric field has brought about the candidate's awareness of the potential of the occupational therapist to make a significant contribution to the team evaluation of a patient. There is no doubt also that the psychiatric team has become very aware of the valuable interaction of the occupational therapist within the team context.

Coupled with this awareness is the increasing realisation by occupational therapists working in the field of psychiatry, that the dynamic use of group-work is effective in both assessing patients and treating them. It is also important to note that most of the occupational therapists working in the psychiatric field in South Africa assess and treat large numbers of patients at one time. This is largely due to the lack of staff. Group-work is the obvious solution to the problem.

The candidate's own experience of psychiatric occupational group therapy encompasses various areas of practice, namely acute psychiatric centres, psychiatric day-patient centres, drug and alcohol-dependant treatment centres and, to a limited extent, chronic psychiatric institutions and a child psychiatric in-patient centre. She has been involved in teaching group-work and assessment techniques to occupational therapy students for many years and the examining of occupational therapy students in these techniques in four different Universities. Hence the development of the hypothesis of this research.

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Only the area of the acutely disturbed psychiatric patient has been used for research in this dissertation and only art and discussion groups used as the medium. Nevertheless the candidate is aware that occupational therapy group-work can be effectively graded to meet the needs of any level of patient in any area of psychiatry. No matter the level of patient, the dynamic use of group-work as an assessment technique should remain fairly constant. In most areas the psychiatric team remains very much the same as that described in this study.

Acknowledgements must be made to the following people :-

1. To the group of colleagues, led by Professor Majorie Concha, Head of the Department of Occupational Therapy at the University of the Witwatersrand. Each member of the group was in the same boat and met regularly to discuss their research. This was a very motivating experience.
2. To my supervisors Professor M. Feldman Professor of Psychiatry, and Professor C. Wyndham Professor of the Department of Biostatistics, both of the University of the Witwatersrand. They gave much support and encouragement.
3. To Dr. S. G. Reinach and Professor H. H. Lemmer of the Institute for Biostatistics of the S. A. Medical Research Institute for the statistical analysis of data and many interesting discussions.
4. To the members of the psychiatric team both at the Johannesburg Hospital and the J. G. Strydom Hospital who so willingly took part in the research. Permission to undertake the research was also given, and honorary appointments established in both hospitals.

5. To the patients who unknowingly contributed to the research; unknowingly because knowledge of the candidate's intentions would, it is believed, have altered or influenced their behaviour.
6. To Mrs. McKay of the NIPR for her assistance in helping the candidate draw up the assessment form.
7. To the ten psychiatrists who contributed to the research by participating in the Likert Attitude Scale.
8. To the occupational therapists who organised the patients and to Louise Kitchin and Pat de Witt for acting as monitors during the group-work.
9. To Janet Jorgensen for her patience and interest in bringing the whole project to fruition.

Presentation of the research has taken place on three different occasions and feedback has been valuable. These occasions are as follows :-

1. At the opening of the New Medical School of the University of the Witwatersrand. One day was set aside for the presentation of student research.
2. At the S. A. Association of Occupational Therapist's Congress in Bloemfontein in July 1983. An abstract of the dissertation was published in the proceedings.
3. At a "Special Interest" meeting of staff of the Occupational Therapy Department of the University of Cape Town in August 1983.

TABLE OF CONTENTS

	Page
PREFACE	vi
CHAPTER I	
1.1 Introduction	1
1.2 Statement and Analysis of the Problem	4
1.3 Hypothesis and Prediction Based on Same for Testing	5
1.4 Objectives	5
CHAPTER II PRELIMINARY STUDY	
2.1 Introduction	7
2.2 Purpose of Study	13
2.3 Materials and Methods	13
2.3.1 Brief Description of Pilot Study and Results	13
2.3.2 Research Design	14
2.4 Results	15
2.5 Conclusions	19
2.6 Discussion	20
2.7 The Assessment Form	21
CHAPTER III MAJOR STUDY	
3.1 Introduction	22
3.1.1 The Use of Group-Work for Assessment	24
3.1.1.1 Social Facilitation	25
3.1.1.2 Spontaneity	27
3.1.1.3 Communication	28

3.1.2	The Use of Art Groups for Assessment	30
3.1.3	The Use of Discussion Groups for Assessment	38
3.1.3.1	Expressive Language	42
3.1.3.2	Demonstrative Language	43
3.1.3.3	Symbolic Language	44
3.1.4	Summary	47
3.2	Purpose of the Major Study	47
3.3	Research Design	48
3.4	Limitations of the Study	50
3.5	Materials and Methods	51
3.5.1	Study Methods	51
3.5.1.1	Sample Selection	51
3.5.1.2	Description of Procedure	54
3.5.1.3	Precautions	57
3.5.1.4	Assessment Procedures used by the Members of the Psychiatric Team	58
3.5.1.5	Description of the Group Techniques used in this Study	59
3.5.2	Data Analysis	67
3.6	Results	
3.6.1	Results of the Statistical Analysis of Data by Professor H. H. Lemmer	72
3.6.2	Analysis of the Results	74
3.7	Conclusions	74
3.8	Discussion	76

CHAPTER IV

4.1 General Conclusions

80

4.2 Discussion

81

4.3 Finale

93

APPENDIX A

94

APPENDIX B

97

LIST OF REFERENCES

98 - 103

TABLE OF ILLUSTRATIONS

		Page
CHAPTER II		
TABLE I	Likert Scale	16
TABLE II	Scoring of Likert Scale	18
CHAPTER III		
FIGURE I	Art-Group	60
FIGURE II	Discussion Group	66
TABLE I	Table used to Correlate Data	69
TABLE II	Indicating the Presence of Certain Characteristics according to five Evaluators	70
TABLE III	Numerical Weighting of each Evaluation	71

CHAPTER I

1.1 Introduction

Group work in occupational therapy has developed rapidly over the last ten years. From journal literature available and university syllabi it would appear that the occupational therapy training in group work has kept up with the demand in the clinical field in South Africa. This demand stems from many varied areas of occupational therapy and is not confined to the psychiatric field. These techniques are also used with physically disabled patients of all ages.

However, with the increase in the use of group work in occupational therapy, there has not, it would appear, been a corresponding implementation of research into the effectiveness of group techniques in the assessment and treatment of patients.

Fransella (1982) when working as an occupational therapist in a psychiatric hospital in 1960, posed the question : "How do I know that what I am doing is of any use?" (p.246) She mentions that occupational therapists today are increasingly concerning themselves with research, and that research involving psychological measurement in particular, is far more difficult than it would appear. It is however essential if, for example, the occupational therapist is to make an accurate assessment of a patient.

The contribution of the occupational therapist to the team approach in the treatment of the psychiatric patient has been firmly established since the inception of occupational therapy as a service in psychiatric

hospitals in 1905 in Germany. However, an increasing awareness of the need to develop well researched and scientific methods of assessment and treatment are highlighted by Tiffany (1982) in the following statement :-

"It has long been a major concern to occupational therapists to develop the means to do accurate assessments of the strength and needs of their clients so that clearly relevant goals and plans for treatment can be developed." (p.IV and Foreword)

Very little evidence is available of occupational therapists comparing their assessment and treatment techniques with the rest of the therapeutic team, in fact, they have in the past relied on positive feedback and a general "feeling" that they are contributing positively. Large patient loads and a scarcity of occupational therapists, particularly in the remoter areas of the country, have certainly hampered efforts in scientific research.

These factors discussed above have contributed significantly to the need to initiate research into the effectiveness of occupational therapeutic techniques.

Assessment of psychiatric patients is another aspect of occupational therapy which has also developed significantly over the last ten years in South Africa. Assessment of a psychiatric patient's psychopathology and functioning ability in all spheres of life are seen as essential to the planning of effective treatment in occupational therapy. There is also no doubt that this assessment contributes to the psychiatric team's evaluation of a patient which in turn contributes to the overall treatment.

Hemphill (1982) states :-

"The mark of a professional evaluator is one who uses learned techniques to evaluate specialised patterns of

behaviours for a specific purpose that focuses on a specific content area." (p. VI : Preface)

With the emergence then, of group work in psychiatric occupational therapy, the occupational therapist is using a "learned technique" which has the potential for quick, effective assessment of more than one patient at a time. It is hoped that the reliability of this assessment will be determined by this study.

Lastly, one must focus on the "tools" of the occupational therapy trade. One of the major advantages which an occupational therapist has in the assessment of any patient, is the access to observation of activities used in the assessment process itself. In this study it is activity used within the group context, namely discussion and art, which is the actual medium for assessment. Therapeutic activities such as art and discussion, when used by the occupational therapist in a carefully structured treatment and assessment situation, are major facilitators of interaction between patients in a group. Because these activities are familiar and carried out in an atmosphere which is secure and relaxed the patient is likely to participate. Even if he is unable to do so or does not want to, the scene is still effectively set for observation and assessment by the occupational therapist.

Bearup (1982) sums up this aspect of occupational therapy in the Australian Sylvia Docker Lecture when she makes the following statement "occupational therapists have a reputation for their practical skills and for their ability to accomplish goals quickly, without a fuss." (p. 51)

It would appear then from all the above factors, that occupational therapeutic group techniques have potential for the effective assessment of psychiatric patients.

1.2 Statement and Analysis of the Problem

It has not been hitherto determined how reliable occupational group therapy is as an assessment procedure with acutely disturbed, adult psychiatric patients.

To solve this problem it will be necessary to investigate the following :-

- 1.2.1** The aspects of psychiatric assessment considered to be valuable in terms of the team evaluation of a patient. This should be determined by the leader of the team, namely the psychiatrist.
- 1.2.2** The extent to which the occupational group therapy assessment of psychiatric patients compares with those assessments made by the other members of the professional team over a longer period.
- 1.2.3** The extent to which the candidate's assessment made during group work, compares with that made by the resident occupational therapist whilst assessing the patients during various other activities.
- 1.2.4** Whether the procedures used for assessment namely art and discussion groups, are effective and reliable tools of assessment and whether any difference between the two methods exists.

- 1.2.5 As a secondary consideration because it is not seen as a problem, it will be interesting to note the level of interrater reliability that exists between the members of the two psychiatric teams used in the study. This result should influence the conclusions of this study.

1.3 Hypothesis and Prediction Based on Same for Testing

The occupational therapist, working closely with the acutely disturbed adult psychiatric patient during group work, is able to make an assessment of aspects of the patient's psychopathology and functioning, which does not differ significantly from the assessment made by other members of the psychiatric team over a longer period. This assessment made by the occupational therapist is a reliable contribution to the team evaluation of a patient.

1.4 Objectives

- 1.4.1 To compare the evaluation/assessment of a psychiatric patient based on the candidate's single group observations with those based on the individual observations made by other members of the psychiatric team over a longer period of time.
- 1.4.2 To validate the role of the occupational therapist in the use of group techniques for assessment purposes. This in turn should highlight the valuable contribution which the occupational therapist is able to make to the team evaluation of a psychiatric patient.
- 1.4.3 To contribute to the research literature in occupational therapy.

- 1.4.4 To contribute towards the planning of priorities in student training in occupational therapy.**

CHAPTER II

PART I PRELIMINARY STUDY

2.1 Introduction

The purpose of a preliminary study is to integrate the results of a pilot study into the formulation of an attitude scale which is to be used as the basis of an assessment form which will be implemented in the major study in Chapter III.

It is general practice in the psychiatric field in South Africa for the acutely disturbed adult patient who is hospitalised to be assessed by a multidisciplinary professional team led by a senior psychiatrist. Each member of the professional team is trained to assess and observe the behaviour and condition of the patient. The assessors meet at regular intervals to discuss the patient and to contribute towards the formulation of a diagnosis, as well as to devise a treatment strategy. The occupational therapist is considered to be a vital member of this team. However, it has not, to the candidate's knowledge, ever been defined exactly which aspect of the occupational therapist's assessment of the patient would be most valuable as a contribution to the team evaluation. Kaplan and Sadock (1981) have set guidelines for the clinician for assessment in psychiatric practice. They explain that every therapeutic situation has potential for the "interviewer" to become aware of and be sensitive to the patient's responses and recollections and to take note of specific feelings which accompany these responses. They emphasise the fact that in order to formulate a diagnosis the mental status examination should

describe every area of mental functioning of a patient. This reinforces the fact that a team approach, with the input of observations of the patient during his everyday activities, will add to the description and classification of the patient's mental functioning.

Fidler and Fidler (1978), whilst describing the occupational therapist's contribution to the total assessment of the psychiatric patient, emphasise the importance of the inclusion of an evaluation of the patient's sensory, motor, psychological and social status as well as being able to identify those factors in the environment which hamper the patient's ability to carry out everyday activities. Mocellin (1982) sums up this aspect of assessment in this way :-

"Because there are degrees of competence and incompetence, degrees of adaptation and maladaptation, degrees in the ability to cope or not to cope, it is important for the occupational therapist to provide functional assessment for the patient." (p.113)

King (1978) also emphasised the fact that occupational therapists working in the psychiatric field should be able to give information to psychiatrists and other professional members of the team in order to supply a rationale for their treatment plan. She also emphasised the fact that it is time for occupational therapists to demonstrate the fact that they understand physical etiologies and are very willing to contribute on a scientific level towards treatment. This in turn will secure the place of the occupational therapist in the treatment of mental illness.

Remocker and Starch (1982) have also emphasised the occupational therapist's contribution at a team level to the assessment of a patient. They provide a description of group exercises which includes an indication

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of the aspects of a patient's behaviour which can be observed or assessed during the exercise. Their conclusions about the patient's mood, his behaviour and insight, his ability to express feeling and his ability to communicate and be spontaneous, give valuable guidelines to those concerned with the total treatment of the patient.

One should not lose sight of the fact that whilst determining the dynamic team contribution of the occupational therapist in this study, one must also take into consideration the fact that the results should also contribute to the effective assessment of the patient leading to appropriate treatment in occupational therapy. Hasselkus and Safran (1976) in describing assessment procedures in both patient treatment and research settings, emphasise this point. They discuss the contribution of the occupational therapist's assessment towards establishing treatment goals and developing effective treatment techniques as well as emphasising the use of this assessment in determining his/her own patient's treatment response in occupational therapy.

Aspects of psychiatric assessment considered to be valuable in terms of a team evaluation of a patient, which could be reported by the occupational therapist, are therefore to be determined. An attitude scale is to be implemented with a group of independently practising psychiatrists for this purpose. As previously stated one of the major purposes of determining the psychiatrist's attitude in this respect, is to gather data which can be used on the assessment form in the major study. In this way a set of data should be collected that is relevant to the formulation of a diagnosis. It is interesting to note that Brayman and Kirby (1982)

whilst developing the COTE (Comprehensive Occupational Therapy Evaluation) also bring to light this important consideration by determining the attitude of the psychiatrist; they state that

"The psychiatrist monitoring the effects of new medication may be more interested in a client's fine motor performance on an occupational therapy project than in the extremes of affect that are so often reported." (p.214)

The Likert Attitude Scale is one which is easy to compile and is also quick and easy to complete by volunteers involved in the research. According to Nieuwoudt (1976) attitude scales are the principal method of measuring attitudes, but it must be appreciated that they are not infallible. It is possible that if the participant does not wish to reveal his real attitude, he may be able to represent his attitude falsely. This is a variable which needs to be given consideration by the candidate.

The items to be used on the Attitude Scale were derived from the pilot study. This study acted only as an indication on aspects of function and psychopathology which it is possible for the occupational therapist to assess during creative group-work. Hemphill's (1980) article on mental health evaluation is particularly relevant here. She reports on evaluations (assessments) which are used in occupational therapy which resulted from surveys of methods of patient evaluations being taught to students. She concludes by stating that none of the evaluations listed in the study had been standardised. She also states that the therapists involved in the study expressed the need to standardise occupational therapy evaluations. Minas (1978) reinforces this view by saying that the only way that the effectiveness of the "creative therapies" can be accepted by the medical profession is if the basic scientific principles are laid

open to testing. Ehrenberg (1982) states that there has in fact been no research done on the validity of the therapist's observations during the assessment period.

When the results of the attitude scale are complete, the development of the assessment form can then proceed. Unfortunately no comprehensive guidelines for this procedure were to be found at the time of the study. The development of the COTE (Comprehensive Occupational Therapy Evaluation) by Brayman and Kirby (1982) was published too late to act as a guideline to this study but it is interesting to note that the assessment procedure evolved along similar lines. Three of their objectives in devising the COTE system of assessment are similar to those of this study, i.e. firstly to act as an identification of behaviours in patients that were relevant to the practice of occupational therapy, secondly "to define the identified behaviours in such a manner that they could be reliably observed and rated by two or more therapists", and thirdly "to direct the information on the scale primarily to the busy referring psychiatrists". (p. 213)

Hasselkus and Safrit (1976_g) stress the importance of devising a reliable assessment form which should give assistance in the diagnosis of a patient's condition and planning of treatment. They also stress the importance of the assessment being concise and to the point so as to report the patient's progress to those persons within and without the psychiatric professions. They continue by stating that using common sense and logic is not enough,

"The principles of measurement theory must be followed to ensure that the test is accurately measuring what it is intended to measure (validity) and that the precision or dependability of the test is acceptable (reliability)." (p. 429)

Hasselkus and Safrit (1976_b) also stress the difficulty in the development of an assessment form when the aspect of a patient to be assessed can only be observed in an indirect manner, because incorrect inferences can be made. The more abstract and indefinable the aspects of assessment are, the more difficult it is to set up procedures to measure them. This is particularly true in the assessment of psychopathology.

Expert advice was therefore sought from the National Institute for Personnel Research in Johannesburg in devising the assessment form itself. Advice given followed that of Garfield (1982) who maintains that in order to obtain a high degree of reliability the items on the assessment form must be such that they can only be interpreted in one way, especially when working with more than one assessor. "There should be no double meanings." (p.321)

It is interesting to note that the candidate arrived at 52 items of assessment divided into five categories to be placed on the assessment form, namely :-

Affect	18 items
Thought Processes	5 "
Social Behaviour	12 "
Communication	10 "
General	7 "

Bloomer and Williams (1982) used 5 tasks to rate ten different functional behaviours in their development of the TOA (Task Orientated Assessment) and Clark, Koch and Nichols (1982) arrived at a 21 item scale which in fact measured 5 factors in their Factor Analytically Derived Scale.

In conclusion it is important again to emphasise how great was the need to develop an effective measurement tool in order to validate this study as a whole. Ehrenberg (1982_a) states that much work has still to be done before the assessment process in occupational therapy can be considered to be reliably researched and that it is the responsibility of that segment of the profession of occupational therapy dedicated to the treatment of psychologically disturbed individuals to "develop a relatively objective means of specifying target problems and evaluating treatment effectiveness." (p.166)

2.2 Purpose of the Preliminary Study

The purpose of the preliminary study is to determine which of the aspects of assessment listed in the results of the pilot study are to be used on an assessment form which is to be used as an integral part of the major study.

2.3 Materials and Methods

2.3.1 Brief Description of the Pilot Study and Results

The purpose of the pilot study was to determine during group-work which aspects of psychopathology and functioning it is possible for the occupational therapist to assess in the adult patient suffering from a psychiatric illness.

Eight art groups with music and two discussion groups were carried out for this purpose by the candidate.

Approximately seven adult patients of various ages, diagnosed as suffering from acute psychiatric illnesses, attended each group. There was a random selection of patients, i.e. there was no specific criterion for selection. Any available patients attended the groups.

Assessment took place by observation of behaviour and the patients participation in activity, namely art or discussion.

By the use of a simple frequency table the following aspects of assessment were recorded :-

Affect

Suicidal Tendencies

Spontaneity

Verbal Communication

Non-verbal Communication

Social Behaviour

Presence of Aggression

Self-Image

Self-Awareness

Self-Esteem

Thought Processes

Reality Orientation

Body Image

Level of Anxiety

Reaction to Stress

Insight into Self.

Insight into the Relationship with Others

Insight into Condition

2.3.2 Research Design

In order to select appropriate items from the results of the pilot study, it was decided to measure the attitude of the leader of the psychiatric team, namely the psychiatrist, towards each aspect of

assessment named. The attitude that was to be measured was whether the psychiatrist saw the various aspects of assessment as valuable in the formation of a diagnosis for an acutely disturbed, adult psychiatric patient.

The Likert Attitude Scale, a technique of social psychology used to measure variables, was used in the study.

The 18 items from the pilot study were used on the form. See Table I - page 16.

An attitude was to be expressed in terms of each item in the left-hand column as being very valuable, valuable, uncertain or of little value in the formation of a diagnosis. Ten randomly chosen practising psychiatrists were asked to participate in the study.

As it is important to try and eliminate the possibility of a testee presenting a false image, when filling out the form, personal contact was made and a verbal description of the research was always undertaken. It should also be noted that by reputation, the credibility of the psychiatrists involved in the study was high.

The time taken to fill out the form by ringing the appropriate attitude, was approximately 15 minutes. The total interview and test lasted for + 25 minutes.

2.4 Results

10 completed forms were used to calculate the results.

A 5-point scale was used to indicate the intensity of the attitude.

Scoring was as follows :-

THIS SCALE REFLECTS:-

YOUR ATTITUDE

AFFECT	
SUICIDAL TENDENCIES	
SPONTANEITY	
VERBAL COMMUNICATION	
NON-VERBAL COMMUNICATION	
SOCIAL BEHAVIOUR	
PRESENCE OF AGGRESSION	
SELF IMAGE	
SELF AWARENESS	
SELF ESTEEM	
THOUGHT PROCESSES	
REALITY ORIENTATION	
BODY IMAGE	
LEVEL OF ANXIETY	
REACTION TO STRESS	
INSIGHT INTO SELF	
INSIGHT INTO RELATIONSHIP WITH OTHERS	
INSIGHT INTO CONDITION	

THIS SCALE REFLECTS:-

YOUR ATTITUDE TOWARDS THE CONTRIBUTION THAT EACH OF THE FOLLOWING ASPECTS OF ASSESSMENT
MAKES TOWARDS THE FORMULATION OF A DIAGNOSIS

TABLE I

AFFECT	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
SUICIDAL TENDENCIES	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
SPONTANEITY	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
VERBAL COMMUNICATION	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
NON-VERBAL COMMUNICATION	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
SOCIAL BEHAVIOUR	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
PRESENCE OF AGGRESSION	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
SELF IMAGE	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
SELF AWARENESS	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
SELF ESTEEM	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
THOUGHT PROCESSES	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
REALITY ORIENTATION	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
BODY IMAGE	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
LEVEL OF ANXIETY	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
REACTION TO STRESS	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
INSIGHT INTO SELF	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
INSIGHT INTO RELATIONSHIP WITH OTHERS	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE
INSIGHT INTO CONDITION	VERY VALUABLE	VALUABLE	UNCERTAIN	OF LITTLE VALUE	NO VALUE

Attitude	Score
Very valuable	5
Valuable	4
Uncertain	3
Of little value	2
No value	1

In this case a high score indicated a favourable attitude. A total score for each item was therefore obtained by the sum of the 10 ratings. A mean was taken for each item. See Table II - page 18.

The left-hand column gives the factors being examined, i.e. the 18 items of assessment. The last column reflects those items which scored 4 or over. In rank order from highest to lowest, the items are as follows :-

Items	Mean Score
Affect	4,9
Reality Orientation	4,9
Thought Processes	4,8
Social Behaviour	4,7
Self-Image	4,4
Self-Esteem	4,4
Insight into Condition	4,4
Suicidal Tendencies	4,3
Verbal Communication	4,2
Level of Anxiety	4,2
Reaction to Stress	4,2
Insight into Relationship with others	4,2
Spontaneity	4,1
Non-Verbal Communication	4,0

TABLE II
RESULTS
SCORING OF LIKERT SCALE

FACTORS EXAMINED	RAW SCORE	MEAN SCORE	FACTORS SCORING 4 OR OVER
AFFECT	49	4.9	AFFECT
SUICIDAL TENDENCIES	43	4.3	SUICIDAL TENDENCIES
SPONTANEITY	41	4.1	SPONTANEITY
VERBAL COMMUNICATION	42	4.2	VERBAL COMMUNICATION
NON-VERBAL COMMUNICATION	40	4.0	NON-VERBAL COMMUNICATION
SOCIAL BEHAVIOUR	47	4.7	SOCIAL BEHAVIOUR
PRESENCE OF AGGRESSION	38	3.8	
SELF IMAGE	44	4.4	SELF IMAGE
SELF AWARENESS	39	3.9	
SELF ESTEEM	44	4.4	SELF ESTEEM
THOUGHT PROCESSES	48	4.8	THOUGHT PROCESSES
REALITY ORIENTATION	49	4.9	REALITY ORIENTATION
BODY IMAGE	39	3.9	
LEVEL OF ANXIETY	42	4.2	LEVEL OF ANXIETY
REACTION TO STRESS	42	4.2	REACTION TO STRESS
INSIGHT INTO SELF	39	3.9	
INSIGHT INTO RELATIONSHIPS WITH OTHERS	42	4.2	INSIGHT INTO RELATIONSHIPS WITH OTHERS
INSIGHT INTO CONDITION	44	4.4	INSIGHT INTO CONDITION

Items scoring below 4 are as follows :-

Items	Mean Score
Self-Awareness	3,9
Body-Image	3,9
Insight into Self	3,9
Presence of Aggression	3,8

2.5 Conclusions

Both an attitude of "valuable" or "very valuable" is seen as significant in terms of this research. For this reason the rank order of items is to be disregarded. However, if a psychiatrist sees an item as uncertain, or of little value, or of no value, then this item will not be used on the assessment form.

Therefore, only those items scoring 4 or over were seen as a contribution to the formation of a diagnosis for a patient.

The following aspects of assessment will therefore be used on the assessment form for the purpose of this study :-

Affect

Suicidal Tendencies

Spontaneity

Verbal Communication

Non-verbal Communication

Social Behaviour

Self-Image

Self-Esteem

Thought Processes

Reality Orientation

Level of Anxiety

Reaction to Stress

Insight into Relationships with Others

Insight into Condition

2.6 Discussion

The implementation of this study reinforces some of the views of the theorists discussed in the introduction to this chapter, namely that occupational therapists should validate their treatment and assessment methods by laying them open to test and that standardisation of assessment should take place. They should also be clear as to the contribution they are making in psychiatry because, as the results indicate here, they could be giving information to the team that is not entirely relevant in terms of the diagnosis and treatment strategy of the patient.

It was an interesting result of this study that the presence of aggression, self awareness, body image and insight into self were not considered to be valuable aspects of assessment in terms of the contribution to diagnosis.

It might be argued that these aspects remain a problem in a patient when present and should be treated no matter what his diagnosis may be. This is true, but it is felt that the formation of a diagnosis allows the team to discuss appropriate treatment and that those factors not seen as relevant to the diagnosis for the purpose of this study which deals with team evaluation, should be eliminated.

The result is also an indication of which aspects of assessment

should be emphasised in student training so that the qualified occupational therapist is able to contribute dynamically to the psychiatric professional team.

2.7 The Assessment Form

The 14 items from the above research were used as a basis for the development of the assessment form See Appendix A, page 94.

Some of the items, notably, "Affect", "Thought Processes", "Social Behaviour" and "Communication", were enlarged upon, giving a greater content for a more meaningful assessment of that particular item. Certain aspects of assessment such as "Level of Anxiety", "Reaction to Stress", "Self-Esteem", "Self-Image" and "Suicidal Tendencies" were rearranged under appropriate headings, but each item from the preliminary study is included.

52 aspects of assessment are included on this form, the completion of which takes approximately 10 minutes.

Terminology used is that which is most commonly used in the hospitals in which the major research took place. It will be noted that in a few instances a brief description of the item is given in order that the items be interpreted in one way only.

CHAPTER III

MAJOR STUDY

3.1 Introduction

The experimental research of the major study compares the assessment of a patient, made by the occupational therapist during one group session, with that made by four other professional members of the psychiatric team over a period of a week. The research is therefore testing the relationship between two or more variables.

The theory to be tested is that of the hypothesis and prediction, which states :-

"The occupational therapist, working closely with the acutely disturbed, adult psychiatric patient during group work, is able to make an assessment of aspects of the patient's psychopathology and functioning which does not differ significantly from the assessment made by other members of the psychiatric team over a longer period. This assessment made by the occupational therapist is a reliable contribution to the team evaluation of a patient."

This is not a defined theory that is quoted as a basic premise in occupational therapy. It cannot therefore be considered to be an organised theory. Freedman, Cartsmith and Sears (1974) in their work on research such as this, which tests a specific hypothesis from a theory, state that "The major goal of theory-related research is to evaluate the theory - to determine whether it makes accurate predictions, whether it has limitations, whether it is correct." (p.435)

To test the relationship between the variables, which are the five separate assessments made by the five members of the psychiatric

team and the candidate, a comparison has to be made. To assist the five assessors participating in the study to reach a definite conclusion about a patient, an assessment form was drawn up from the results of the preliminary study (Appendix A). The completion of this assessment form should be effective in overcoming possible bias which may occur in a verbal discussion about a patient. The written comparison of assessments is therefore facilitated. The question to be answered by this comparison is whether the presence of any characteristics noted on the assessment form, can as effectively be noted in a patient who is observed in a group for an hour, as when observed in various activities or on an individual basis over the period of a week.

A similar study by Lerner (1979) describes the use of other psychiatric team members whilst establishing the clinical use and validity of the Magazine Picture Collage as an assessment technique. This study served to indicate at which level of assessment the collage is most useful and to serve as a hypothesis for future research.

It should be noted at this point that the types of group-work chosen in this study, namely art and discussion groups, represent commonly used group-work in occupational therapy. According to Meyerowitz (1979) the use of different types of occupational therapy groups is well documented and that occupational therapists today are trained to use many different types of therapeutic techniques including various types of group-work. She emphasises, however, the potential for development and research into the existing methods of occupational therapy group-work.

The choice of group method was also made so that both non-verbal and verbal methods of communication in a group could be investigated. Art groups facilitate non-verbal expression primarily but verbal expression often follows, whereas discussion groups facilitate verbal expression primarily but non-verbal communication in the form of gestures and body movement is also present. In each type of group, socio-emotional factors predominate and sensitive leadership from a trained occupational therapist is required. The occupational therapist requires a sound knowledge of group dynamics, group leadership and psychiatric conditions, to be able to lead a group effectively. Jennings (1975) in a discussion on creative therapies emphasises the fact that an experienced therapist should respond to the needs of the group by carefully selecting activities which will provide the relief of anxiety and the emergence of hidden tension. Meyerowitz (1979_a) emphasises the importance of creating a therapeutic atmosphere which promotes trust and spontaneity.

3.1.1 The Use of Group-work for Assessment

Homans (1961) states that "the first and most immediate experience of mankind is small group experience." (p.1) This statement lays a theoretical foundation to the reasoning behind the frequent use of group-work in psychiatry. A patient undergoing psychiatric treatment experiences many different situations as he comes into contact with the various therapeutic methods, one of which is undoubtedly the small group. Kaplan and Sadock (1982) reinforce the use of group work in psychiatry by discussing the advantages that the group setting has over the dyadic setting. They stress the importance of the interaction of

the patients in a "here and now" situation, the support of one another, the ventilation of feelings, the imparting of information and the reality testing that takes place in therapy groups.

The interaction of group members is also stressed by Lakin (1972) who states that each individual has his own personal emotional style, thoughts and actions and is responsible for the development of group feelings and his own particular response to it. No matter whether his participation is active or passive he still plays an important role as a member of the group. He also notes that the characteristic behaviours of a group member are brought to the fore during the group procedure and it is possible to see what led up to them and what the consequent reactions are. It is important to note in Lakin's findings that there is a parallel between behaviour in a group and back-home behaviour, and that common occurrences in groups allow the therapist to understand how the patient reacts in many other settings.

Interaction as described by these theorists is the central factor which dictates the success of the assessment process during group-work. It is actually the patient's style of interaction which is observed and noted, be it verbal or non-verbal in nature.

There are three factors intimately related to the interaction of patients in a group. The first is social facilitation, the second spontaneity, and the third communication. All should be considered in this study.

3.1.1.1 Social Facilitation

People generally perform tasks better when they are in the presence

of others, such as in a group, than when they are alone. The arousal of drive is activated by the presence of other people and the motivation behind the performance of the task is known as social facilitation. Theorists such as Tubbs and Moss (1981) describe social facilitation in the following ways. They state that in a small group social influence (facilitation) is a powerful factor which brings about a patient's emotional commitment to a group. Zajonc (1968) describes social facilitation as the theoretical reason for people interacting better in a group. He says that the presence of others in a group brings out dominant and well-developed responses. He says that though there is little evidence that the mere presence of others raises arousal level, it does provide cues to appropriate and inappropriate responses. He does state, however, that the acquisition of new responses is often impaired. Homans (1951_a) describes the elements of group activity as follows :-

"The activities, interactions and sentiments of the group members, together with the mutual relations of their elements with one another during the time the group is active, constitute what we shall call the social system." (p. 87)

The motivating factor behind social facilitation is undoubtedly the need for a person to conform to the norms of the group and the comparison of himself to others in the group. Kelman (1958, 1963) identified three types of social influence namely, compliance, identification and internalisation, which are all relevant to this study.

A patient's compliance is seen when he changes his behaviour in response to others in the group, whom he sees as having the power to punish or reward him. Identification occurs when a patient identifies with another group member who seems more confident than himself

and he therefore behaves in the same manner. Internalisation is the influence which occurs when a patient sees that another group member has similar values or problems to his own and he then behaves in the same way, not to please others, but to overcome his own difficulties.

Social facilitation is therefore seen as one of the most important reasons why interaction occurs in a group.

3.1.1.2 Spontaneity

Spontaneity or spontaneous interaction is a process which is encouraged in all therapeutic group work. It is this spontaneous interaction of the patient that is such a vital link in the assessment process because it is a true reflection of how the patient behaves and what he is thinking. "Spontaneity can be either a response to a novel situation or a new response to an old situation" (Crouch 1982). Spontaneity has been widely researched and documented by Moreno (1977). He has identified four different types of spontaneity, namely, that which is expressed in cultural and social situations, that which is expressed in the creation of new organisms, art forms and patterns of the environment, that which is contained in free expression of the personality, and that which goes into the formation of adequate responses to novel situations. Crouch (1982_a) points out that "all the above types of spontaneity are encouraged in occupational group therapy, but particularly where art is used". (p.1019)

The spontaneous participation of a patient in a group setting is further enhanced by the use of an activity, in this case the use of art and discussion. Meyerowitz (1979_b) states that the most important aim

of using expressive media in groups is to facilitate self-expression and to bring about creative participation. Ehrenbert (1982_b) also states that the use of activities in a group creates a much less demanding and more relaxed atmosphere. This in turn brings about a better milieu in which to assess behaviour and mental and physical function.

Gattuso and Pastura (1968) reinforce Meyerowitz's views in this quotation :-

"Certainly man projects himself through means of expression. He projects his psychology, his mood, his pathology, and he projects this psychological and psychopathological world of his even better the more congenial to the ideopraxic structure the instrument of the projection is." (p. 52)

It is true to say that spontaneity is often enhanced by the activity and the presence and interaction of others in a group; however, where a patient's psychopathology intervenes in the form of disturbances of thought and affect, spontaneity is often lost. A valuable means of assessment is also inhibited. It should be noted that spontaneity is one of the factors deemed to be an important aspect to be noted in the assessment form that is to be used in this study.

3.1.1.3 Communication

Human communication is a subject that has been widely discussed by theorists such as Wenburg and Wilmot (1973), Fourie (1975) and Tubbs and Moss (1981_a). When discussing communication in a small group Tubbs and Moss (1981_b) stress the influence that group members have upon one another, the satisfaction obtained from maintaining membership of a group, the interactional aspects, the assumption of roles, the dependence on one another and the communication that takes place face to face.

It is this communication, verbal and/or non-verbal, that is the actual means by which the occupational therapist is able to assess the patient during group-work.

Homan's (1951_b) definition of a group describes this central factor :-

"We mean by a group a number of persons who communicate with one another often over a span of time, and who are few enough so that each person is able to communicate with all the others, not at secondhand, through other people, but face-to-face." (p.1)

It is interesting to note that the presence of joy, anger and hostility in a patient, according to Festinger (1968), produce a force to communicate in a group. Therefore the use of activities that promote these emotions is important. Robbins (1980) emphasises the importance of non-verbal interchange which has the advantage of not making verbal demands. This is important, when working with patients who find it difficult to communicate verbally, e.g. the depressed patient. According to Feder and Feder (1981) "successful therapy in Freudian analytic practice, depends on 'authentic' communication by a patient - that is, a free and uninhibited release of depressed feelings and urges." (p.25) It is therefore vitally important that the occupational therapist is able to understand the communication taking place. As Aranguren (1967) points out every gesture must be seen as a sign that is significant and must be anticipated as quickly as possible.

We see then that all three factors, social facilitation, spontaneity and communication are vital to the assessment process in group work.

Literature on the specific use of group-work as assessment, is not easy to find. Swanson (1978) however does mention that a

psychotherapy group does provide "a stage for action, interaction and reaction" (p. 6) and that there is usually typical behaviour to be found in a patient, whereas Benjamin (1983) states that his psychodrama groups became a "laboratory for creative experience, development and observation, and a potent organic psychobiological entity." (p. 897) Crouch (1975) and (1977) emphasises the importance of all types of group-work for the observation and assessment of patients for diagnostic purposes.

Music and movement are activities which are used frequently in group-work. Most of the literature deals with the therapeutic nature of these activities and little mention is made of the potential for assessment, except by Hugo (1978) in her discussion on "movement and emotional expression". She describes the assessment of movement during group-work as having significant value in diagnosis.

Specific details on the use of art and discussion as media for assessment in groups is to be found in the following two sections of this chapter.

In conclusion it is important to note that Cartwright and Zander (1968) advocate short-term group-work, as in this study, for assessment purposes. They state that there is a problem in trying to assess a patient in group therapy over a long period. The reason for this is that the cohesiveness and norms that have developed may exert pressure on a patient to conform. Natural behaviour would then be minimised.

3.1.2 The Use of Art Groups for Assessment

Journal articles, papers presented at congresses and communication with occupational therapists indicate that the use of art as an expressive

medium in group work has become general practice in many occupational therapy programmes throughout the country. Many occupational therapists show interest in this type of treatment and occupational therapy students are instructed in the therapeutic use of the medium of art. The scope of Occupational Therapy as dictated by the South African Medical and Dental Council in 1978, includes the use of group handling techniques as well as "activities requiring varying levels of verbal and non-verbal communication and varying degrees of participation" and "activities requiring varying levels of self-expression" (p.138). Art groups fit into this framework. They were therefore considered to be an important type of group-work to use in this research.

There is, however, confusion in the terminology used when art is presented as an expressive medium in a group. The question is whether it should be called art therapy, expressive art therapy, creative therapy, projective art, or visual arts therapy. A wide range of diverse definitions are available. Wallace (1977), a Jungian analyst, says "the beauty of art therapy is that in the last analysis it is not definable, in the same way that the creative process - no matter how much we can and do say about it - is ultimately a mystery." (p. 89)

For the purpose of this study the terminology to be used is "art-group". An "art-group" shall be defined as :-

"A group of two or more people led by an appointed leader in which a variety of art media is used to encourage creativity and social interaction and to facilitate the communication of problems, ideas, plans and emotions."

Art itself is seen as a creative, expressive activity in any setting in which it is used. Morris (1982) explains that no matter how art is

used, whether it is imitating natural objects or creating abstract novel work, the emphasis is on the personal ingenuity of the patient as he interprets the theme. This is a very important point.

It should also be realised that art used in any way in a group is always projective. The minute that a patient puts pen or brush to paper he begins to project something of himself. Even refusal to participate projects an image! Stevens (1973), in her report on a study day where the use of projective techniques in psychiatry were discussed, describes many different types of activities as being projective, namely poetry, contact activities, pottery, warm-up techniques, art and music.

Why has art used in a group, potential as a powerful tool of assessment? One of the reasons for this is that it is a very creative process. Du Tolt's (1980) theories of creative ability have formed a firm basis for the development of psychiatric occupational therapy in South Africa. One of the fundamental premises which determine the understanding of the concept is that :-

"The level and quality of an individual's psychical development will, in fact must, determine the nature, quality and extent of his creative ability. The psychical level is thus the source or matrix whilst the creative art represents the product or human evidence of that psychical quality." (p. 7)

Robbins (1980₂) compares the nature of the creative experience in art and in therapy and calls it the coenesthetic experience. He explains how an art therapy session can become totally engrossing. There also seems to be a loss of time and space. "Thus, when therapist and patient are working well, they are finely attuned in resonance, yet are distinctly separate." (p. 22) He explains that art therapy can become a total

experience for a patient "in which perception, affect and sensation join cognition at the same point in time and space." (p. 29) Sircello (1972) reinforces this view by explaining that most people express their moral and spiritual ideals in an abstract way whilst involved in art. He says it is a very self-expressive medium.

Jennings (1975_a) whilst discussing the creative process, says that the impulse to create is one of man's basic impulses. She explains that it is the psychological reason why man makes art in the first place. He has a need to externalise internal images, a need to preserve sensuous experience, a need to communicate to others imagery and experience, a need to give expression to fundamental impulses and a need to symbolise disparate and individual aspects of experience so that he can find meaning for them. She also explains that the self-expression which takes place in the art experience is cathartic in nature. Clearly this creative process is one of the reasons why a patient becomes involved on a very personal level while attending an art group.

It is this authentic expression which is the expressive art therapist's

aim. As Feder and Feder (1981_a) explain : according to the Freudian model :-

"In order to deal with the preconscious, it is necessary to accept the irrational, and the communication between the conscious and unconscious is expressed symbolically through images." (p. 25)

They explain that although the Freudian theoretical formulations have been the centre of debate, they did lay the foundations for modern psychotherapy and in doing so, for the art therapies. The functioning of the preconscious level is undoubtedly of special interest to the art therapist because the

spontaneous expression itself is a very creative process. Crouch (1982_a) also describes the creative process of art therapy as being intimately linked with the emergence of spontaneity. This concept is discussed in 3.2.2. "Expression, speaking through the symbol, is facilitated and determined by inherent qualities of the creative process." (Bassin, Lynshak, Robbins 1980) (p. 50). Art then has something very special to offer because it is a non-verbal way of communicating and airing feelings and problems.

With this in mind let us look at the potential for assessment during the art group process. Much work has been done and documented by occupational therapists, art therapists and others with psychiatrically disturbed patients and those with substance - abuse disorders. O'Hare (1981) in defining psychopathological art says that many pictures done by definitely diagnosed mental patients, in and out of hospital, are very good artistically but very often lack harmonious integration. This could either be their psychopathology or because they were less adequately trained in art. He stresses however, that from a psychiatric point of view, we are not only interested in the artistic quality, but also in many other facets of patient's functioning.

There is clearly a distinct relationship between some mental disturbances and the ability to be able to create in the form of works of art, poetry and music. It is a well-known fact that some psychotic or psychopathological art reaches great popularity and has often an accompanying value in terms of large sums of money. Prinzhorn's (1972) vast work on the artistry of the mentally ill describes the above

point in detail, but explains that very little research has taken place as to the reasons for this relationship. Prinzhorn (1972_a) emphasis is mainly on schizophrenic pictures which he says have variety, charm and abundance. He says that recent pathographic investigations stress the theoretical psychopathological aspects of this type of art. He states that it is possible to recognise symptoms in the pictures which force us time and again to recognise that this is still a source of psychiatric insight that we are not using to the full potential. He emphasises the fact that every clinical observation of a creative patient would be very valuable but would make heavy demands on the observer who, he stresses, must be a master of the subject. Another important factor that Prinzhorn brings to light is the proof that the productivity of the schizophrenic patient seems to survive the general disintegration of the personality. Billing (1968) states that there is a need for schizophrenic patients to draw or paint because they lose their ability to communicate effectively verbally.

Sturgess and Maas (1981, also describe the characteristics of paintings of schizophrenics who are in a depressed state. Their study is similar to that of this research but has one major difference. The three independent raters used in the study rated the actual pictures of the patients as showing aspects of depression according to the BDI (Beck Depression Inventory). The candidate, however, in her study, has used observation of behaviour and execution of the art work, as well as social and verbal interaction as the basis of assessment, whilst the patient was involved in the art group.

One important point made by Sturgess and Maas (1981_a) is that :-

"art work produced by people with a psychosocial disorder has been considered, not only in terms of its aesthetic qualities, but also in terms of its contribution to the process of diagnosis, and of its value as a treatment technique." (p. 59)

O'Hare (1981_a) gives details as to the amount of productivity one can expect from the various types and degrees of psychiatric disturbances.

His study can be used as a guideline in the assessment process.

Malcolm (1975) describes the use of art as a projective technique with psychiatric patients of varying diagnosis at the Royal Edinburgh hospital. She subscribes to the use of art as an aid to diagnosis, but makes it clear that it is only one part of the contributing data accumulated by the team for the purpose of diagnosis. Monroe and Herron (1980) and Dollin (1976) however, in their articles on using art as a treatment medium in a psychiatric day hospital and in-patient hospital respectively, do not mention the assessment value of the technique at all.

The occupational therapist working with the long-term psychiatric patient also uses art groups to good advantage. Wilson (1983) makes it clear that art used with these patients is used as a method of communication and provides an opportunity for the expression of personal perceptions. In this setting the diagnosis has long ago been made so the emphasis is not on assessment for diagnostic purposes, but assessment of the patient's improvement and progress and for assessing effectiveness of treatment.

Jakab (1968) whilst describing the coordination of Verbal Psychotherapy and Art Therapy, describes graphic expression as a means whereby the therapist can better understand the patient's problems by the patient's

own interpretation of his work. She stresses the point that in order for the art therapist to observe and report in a meaningful way on the patient's behaviour to the treatment team, she must be very familiar with the elements of the media used.

Tayal (1968) says "The use of art as a projective device for diagnostic purposes and as an adjunct to therapy is increasingly becoming an accepted practice." (p.188) Pisarovic (1968) also discusses the possibility of using the analysis of the deviation of form in creative art as an aid to the formation of a differential diagnosis and for prognostic purposes.

Mention should be made of a study which has described the use of colours in art therapy as an aid to diagnosis. This aspect of assessment assumes a small role in the total process of assessment in this study, but is an area where very little research has taken place to date. Pasto (1968) in his study on a bio-mythology of colour, postulates that the colour black indicates an absence of colour or affect and shows that a patient is tense, pent-up and aggressive whilst he suggests that "the paranoid schizophrenic goes for blue-black, a painful but sought after contact with a distant illusive father (blue) in a depressive (black) feeling of hopelessness and defeat." (p.151)

There are many other examples of colour which he says become significant from an emotional point of view when a person is stressed or threatened in terms of his mental well-being. O'Hare (1981_b) also discusses diagnostic characteristics in terms of colour, fragmentation, restriction of ideas, symmetry, etc. As Feder and Feder (1981_b) explain, views such as these remain untested hypotheses and unless

these theoretical formulations are tested under controlled conditions there is no way of proving them.

The article most relevant to this study is that of Sheffer and Harlock (1980). Projective art was used as an evaluation tool in occupational therapy to evaluate short-term psychiatric in-patients prior to the planning of treatment. Small groups sessions lasting from half to one hour were used and the patient was also asked to participate in an interview. Aspects of the patient that were assessed were, cognition, performance, affect/mood, insight, motivation and situational components. Assessment was made by observation of behaviour and execution of the task, and from the patient's disclosure of his drawings. The conclusions show that the use of art in this way is brief and easy to administer and provides quick results.

"It provides information essential for treatment planning for both the occupational therapist and the team. Those results tend to be highly supported by later results of ward observation and psychiatric and psychological evaluation." (p.37)

In conclusion of this section it is important to point out the dynamic interaction that exists between therapist and patient which is similar to that which takes place in a verbal interaction. As stated by Jakab (1968_a) :-

"the art therapist has to master enough knowledge of psychology and psychodynamics of pathological states to be able to interact in a therapeutic fashion with the patient during the sessions in order to be more than just a body-guard or an art teacher." (p.96)

3.1.3 The Use of Discussion Groups for Assessment

For the purposes of this study, a "discussion group" shall be defined as a "group of three or more people, led by an appointed leader,

in which verbal discussion is used in order to promote interaction and socialisation amongst the group members, and also to facilitate the expression of feelings, thoughts, ideas, plans and emotions."

Mumford (1974) provides a definition of her verbal training group which helps to clarify the major difference between art and discussion groups. She says a verbal training group is "a group of twelve people who are engaged in a course of group dynamics. The goal and the content are identical with that of activity groups. However, the major tool for learning is discussions." (p.281)

There is a narrow dividing line between an in-depth discussion group and group-psychotherapy, and this is an important consideration to be discussed at this point. It is clear, as Schechter (1974) points out, that in both types of groups :-

"Patients are encouraged to verbalise ideas and feelings in a supportive atmosphere conducive to self-awareness and individual growth in interpersonal awareness. The therapist assists in directing the group towards constructive methods of communication." (p.152)

However group-psychotherapy is a lengthy process and requires specialist skill in handling by a trained psychotherapist. Major changes in a patient's behaviour and psychiatric condition are the consequences of this type of treatment. It is the candidate's opinion that the undergraduate training of an occupational therapist in this country, is not adequate for that of psychotherapist; post-graduate training would have to be undertaken for the purpose of being solely in charge of a psychotherapy group.

It is however, fairly common practice for an experienced occupational therapist to be brought into a group psychotherapy situation as a co-therapist. Schechter (1974_c) describes her participation in this way, in the Sinai Psychiatric Day hospital in Detroit, Michigan. McCam and Thackeray (1980) discuss the importance of combining the skills and techniques of the occupational therapist and the clinical psychologist in psychotherapy in order to bring about a more therapeutic group. Van Zyl (1966) also describes the role of the occupational therapist in group psychotherapy as a shared responsibility within the therapeutic team. No mention is made of the use of this type of group-work for assessment purposes.

However, since the purpose of this study is to determine the effectiveness of group-work as an assessment technique, it is important to take note of the work done by Priestley, McGuire et al (1978) who in their description of discussion groups, make it clear that there is a definite distinction between the use of group discussion for assessment purposes and that used for group therapy. With the assessment group, once the discussion has started, only a minimum of direction is advisable. This is necessary in order to keep the group members to the topic, and to encourage as many people as possible to make their contribution in order to facilitate assessment. Discussion used in psychotherapy groups, however, emphasises personal exploration, the changing of behaviour and emphasis on the patient doing something practical about his own problems.

It is difficult to know for how long occupational therapists have been using discussion groups in their treatment programmes, as very little

literature is available. Ironically, and in contrast to the use of art-groups, occupational therapists have presented a case both for and against the use of discussion in a group, in such literature as is available. Trop, Garbesi and Loeb (1976) in an article on improving communication skills of psychiatric patients, emphasise the value of the discussion group as a means of determining how a patient functions in society. They state that discussion groups "should be considered to be an important therapeutic tool of occupational therapists" (p.96). Mumford (1964_a) however, in her comparison of interpersonal skills developed in verbal, and alternatively, activity groups, shows a significant increase in the interpersonal skills developed in activity groups compared to those developed in verbal groups. She does not mention the use of these groups for assessment purposes, but the results of the comparison could be significant as far as assessment is concerned.

Why is the use of discussion in a group an effective tool for assessment? One of the reasons is that language does more than just convey a message of words. Tubbs and Moss (1981_a) state that "language is potentially the most precise vehicle we have for interpersonal communication." (p.157) They distinguish two types of verbal stimuli, namely intentional stimuli which are "the conscious attempts we make to communicate with others through speech," (p.29), and unintentional verbal stimuli, which are "the things we say without meaning to." (p.29) Rycenga and Schwartz (1963) on the other hand describe language as being human, verbal, systematic, a form of symbolisation, a means of transmitting information, an acquired form of social behaviour.

Taking all the above factors into consideration, language can be divided into three separate parts: expressive language which is charged with emotion but lacks cognitive significance; demonstrative language, which is mostly non-verbal in nature; and symbolic language which is descriptive in nature. The combination of these three aspects of language during the discussion process lays the patient open for observation and assessment. Each aspect will be discussed separately :-

3.1.3.1 Expressive Language

Sircello (1972_a) says :-

"language is always spoken with some particular 'expression' in the voice, an expression which is traceable to some combination of rhythm, inflection, tempo, emphasis or other features, such as sudden aspiration." (p.88)

It is these features of language which allow us to determine how the patient is feeling as he speaks.

Tubbs and Moss (1981_b) describe the emotional power that the spoken word contains and they stress the fact that the development of a therapist's sensitivity to the response of others brings about an appropriate handling of the patient, who is clearly expressing his feelings through language. They state that "language is by far our most explicit form of communication." (p.157) They also point out that failure in communicating most frequently occurs, not because of the failure to understand the grammar, but because the rhetoric or point-of-view is not understood. Elgen (1980) also emphasises the importance of the therapist being sensitive to and understanding the expressive qualities of language. He also notes that the therapist's own emotional state and past experiences may distort or blind her in determining the expressive

meaning of a patient's language.

3.1.3.2 Demonstrative Language

Demonstrative language is that part of the communicative process which conveys a message by non-verbal means, but is still intimately connected to the verbal message. As it occurs during verbal communication it has great significance as far as assessment is concerned, because the patient may be saying one thing and demonstrating another. Robbins (1980_b) says that because there are many areas of experience that cannot be adequately verbalised, factors such as pain, fear and joy are often demonstrated in a non-verbal way.

Wenburg and Wilmot (1973_a) state that :-

"only a small portion of the meaning one gets from face-to-face communication comes from the actual verbal cues used in the interchange." "The phrase: 'It isn't what he said, it's how he said it!' illustrates that non-verbal elements of a communication transaction are very important." (p. 96)

Authors such as Wenburg and Wilmot (1973_b), Tubbs and Moss (1981_c), Fourie (1975_a) and Birdwhistle (1970) have provided a firm theoretical background to the study of non-verbal communication. All of them identify three different types of non-verbal languages, namely, sign language, in which we use gestures, action language, in which we employ bodily movement, and object language, in which we display material objects as a means of communication.

Semiotics is the term used for the study of non-verbal communication.

Fourie (1975_b) identifies three types of semiotics, namely :-

- visual semiotics, which incorporates all those aspects of non-verbal communication which it is possible to see, such as bodily

movement, facial expressions, gestures, posture, locomotion, proximity and graphic communication.

- acoustic semiotics, which include vocal sounds, music, rhythm, pitch, silences, etc.
- tacesics or tactile semiotics, which incorporates all tactile communications.

All occupational therapists using discussion-group for assessment purposes should be sensitive to and aware of all non-verbal cues that are transmitted by means of demonstrative language by the patient. It should be emphasised that non-verbal information predominates in any face-to-face communication. It gives vital clues to the patient's intentions and emotional responses which are often misread or not present in the verbal message. Tubbs and Moss (1981_q) point out that "we are more inclined to believe the non-verbal message." (p.189)

3.1.3.3 Symbolic Language

Symbolic language involves verbal description and the semantics of the message. Wenburg and Wilmot (1973_c) state that "meanings are in people, are unique for each person, and change over time." (p.93)

It is important to note that different cultures assign different meanings to words and that different contexts or settings also change the meaning of words. This is an important consideration to be taken into account by the occupational therapist using discussion in a group. A patient who states that he is feeling "fine", may mean that he is feeling very well, is fairly well, or is misleading one because he wants to be left alone. It depends on the setting in which it is said, the culture from which the person comes and the demonstrative or expressive

language accompanying the communication.

The Whorfian Hypothesis is described by Wenburg and Wilnot (1973) and Tubbs and Moss (1981_e). They state that our thought is limited by language, in other words, the way that we use language determines our experience of the world. Tubbs and Moss (1973_e) state that "language also enables us to abstract indefinitely from our experience, which is especially important in communicating about abstract relationships - something animals are unable to do." (p. 149) This statement reinforces the dynamic use of discussion for assessment purposes because the patient, through the use of language, is reflecting past experience.

It is also important to be aware of the inferences implicit in most verbal messages. Inferences are made in every context and it is not possible or even desirable to avoid them. One should be able to distinguish between factual and inferential statements. Inference in a patient's speech is often a vital factor in 'hearing' what he actually means, rather than what he is actually saying. This is an important part of assessment.

The above three aspects of language are seen as very important to the communicational process which takes place in a discussion group. They are the means by which an assessment of a patient can be made.

Sparse literature on the implementation of discussion groups is to be found. However, guidelines on leading discussion groups are given by Priestley, McGuire et al (1978_a) in their work on social skills and personal problem solving. Pollak's (1975) entire publication deals with the leadership of discussion groups and describes policy and program

development, records and the theory of leadership. One important factor that is stressed, is the actual physical setting of a discussion group. She emphasises the fact that group members prefer a familiar meeting place, they tend to become accustomed to a particular place which must be accessible, and above all they must feel "safe". Guidelines are also given on the preparation of the leader for the discussion group, the content of the discussion and the handling of discussion with different groups.

Harris (1977) in the introduction to her work on the group treatment of human problems, focuses on the social learning approach to group work, which she says "lends itself to evaluation at any point; it is economical to the client, and the length of treatment is considerably shorter than that of other psychotherapeutic interventions." (p. vii) Much of the group work described in this volume incorporates the use of discussion as a medium but used at a psychotherapeutic level. However, guidelines that could be used by an occupational therapist include the use of group work with particular types of psychiatric problems, e.g. phobias, anxiety and alcoholism.

Studies of psycho-linguistics (the study of speech and language behaviour) are also relevant to the study of discussion groups. Kaplan and Sadock (1981_c) state that :-

"by applying the new methods of psycholinguistics to psychiatric populations, investigators have added significantly to the understanding of language behaviour in schizophrenia, mania, depressions and some neurotic disorders." (p. 81)

They state that it is important to note that a primary and pathognomic symptom of schizophrenia, as noted by Bleuler and his followers, is

thought-disorder. Speech and language behaviour are therefore seen as an objective means through which one can delineate an underlying deficit in thinking. The use of discussion facilitates the observation of language and speech behaviour.

Robbins (1981_o) sums up the dynamic use of discussion as communication, by stating "communications theory offers the expressive therapist a new language to understand the subtle mixture of double-binding affects that are contained in words as well as actions." (p. 34)

3.1.4 Summary

The three sections of the introduction discuss the theoretical basis for the use of experimental research in this study, describe the use of group-work, in particular art-groups and discussion groups, in the assessment of psychiatric patients. Bassin, Lynshak and Robbins (1980_a) adequately sum up this section by stating "Expression, speaking through the symbol, is facilitated and determined by inherent qualities of the creative process." (p. 50) They also state that experiences cannot always be expressed verbally. Because art is not restricted to the "usual boundaries of verbal syntax or logic", (p. 16), it is often a more successful means of communication by a patient. Therefore both discussion and art have been chosen as a means of assessment within the group context in this research project.

3.2 Purpose of the Major Study

The purpose of the major study is to compare the assessment of patients made by the candidate during group-work, with those assessments made of the same patients, individually, by four other members of the psychiatric team.

3.3 Research Design

The type of research employed in this study is "research testing a specific hypothesis from a theory", and is analytical in nature.

The experimental research method has been employed in which the assessments made by four members of the psychiatric team (the independent variables) who have been randomly assigned to the experiment, are compared to the assessments made by the candidate (dependent variables).

Interfering variables and the control of these are described as follows :-

- i) To avoid bias, a major interfering variable, professional members of the team and patients were allocated randomly to the experiment. They were not chosen on the basis of an attribute known to the candidate, but according to the criteria discussed in 3.5.1.1.
- ii) If the four professional team members had always assessed the patients in the same order, i.e. the psychiatric registrar first, then the social worker, etc., there could be a confounding of the difference between evaluators and the time lapse. Randomisation of order of assessment took place in order to eliminate this factor.
- iii) Preconceived ideas or preperceived behaviour of a patient taking part in the experiment would bias the candidate's assessment of that patient. This was avoided by the choice of patient being made by another, the resident occupational therapist. The candidate had never met, heard about, or seen any of the patients being assessed before.
- iv) In order to prevent bias in assessment and to bring about uniformity of procedure, a monitor attended every group session. The monitor

was an occupational therapist by profession, and her function was to observe the group procedure and the assessment of the patients, thereby helping to validate the research.

- v) In order to eliminate bias towards a particular group method, an equal number of art and discussion groups were held. The actual method of each art and discussion was the same for every group held.
- vi) An interfering variable of differences in competence on the part of the professional members of the team in their ability to assess a psychiatric patient, was difficult to eliminate. However, randomisation of the selection of persons belonging to a particular profession and a certain amount of change of the person representing that profession helped to some extent to overcome this problem. It was important that the dependent variable remained constant.
- vii) Differences in terminology used, the understanding of concepts and the categorisation of items of assessment were controlled by a standardised assessment form. This form and the purpose of the study was explained in the same way to each assessor.
- viii) Items 1-6 on the assessment form (see Appendix A) could be altered to read either morning or afternoon depending on what time of day the patient was assessed by the candidate. Since it is pertinent to psychiatric assessment whether a diurnal variation in depression is evident in a patient which would indicate what type of depression is present, it was essential that the four assessors assessed this aspect of the patient's affect at the same time of day as the candidate otherwise an interfering variable in assessment items would exist.

If a patient was assessed by the candidate in a morning group, items 2, 4 and 6 were deleted from the assessment forms for that patient, and if assessed in an afternoon group, items 1, 3 and 5 were deleted.

- lx) Differences in the training of professional team members in psychiatric assessment constituted an important interfering variable. To try to overcome this problem, only psychiatrically trained personnel were used in the study. As far as could be ascertained, all the team members had a basic psychiatric training similar in content to that of the candidate's occupational therapy training, i.e. each member had attended a university-based course in psychiatry and had qualified through examination in the subject.
- x) Because of the possibility of an alteration in behaviour, an interfering variable, the individual patients being assessed were unaware that the assessment was taking place and no special attention was paid to them in the group.

3.4 Limitations of the Study

- 1) The study was limited to two areas for the treatment of the acutely disturbed adult psychiatric patient, namely the psychiatric wards of the Johannesburg Hospital and the psychiatric wards of the J.G. Strydom Hospital, Johannesburg. Both areas have similar psychiatric orientations as far as treatment is concerned, and have similar staff structures and programmes. They are both training centres in psychiatry for all disciplines.

- ii) The assessments of thirty acutely disturbed psychiatric patients were used in the research analysis.
- iii) Four members of the psychiatric team, namely the psychiatric registrar, psychiatrically trained nurse, psychiatric social worker and occupational therapist participated in the study, with whose assessments the candidate compared her own.
- iv) The period allowed for a team member to assess a patient was limited to one week.

3.5 Materials and Methods

3.5.1 Study Methods

3.5.1.1 Sample Selection

i) Patients

Patients to be assessed by the candidate and then subsequently by the four other assessors were selected by the resident occupational therapist according to the following criteria :-

Age and Sex : Between 18 - 65 years old; male or female.

Culture : White patients from any culture as long as they could speak and understand English or Afrikaans.

Diagnosis : There was no selection according to diagnosis. The patients participating in the experiment were however all in-patients in a psychiatric unit and were suffering from one of the following psychiatric disorders :- (Classification taken from the D.S.M. III) Organic Mental disorders,

Substance-use disorders, Schizophrenic disorders, Affective disorders, Anxiety disorders, Somatoform disorders, Dissociative disorders and Personality disorders.

Stage of Psychical Recovery : There was no selection of the patient's functioning according to the stages of psychical recovery. (Du Toit, 1980₂).

Other Factors : The patients had to be completely unknown to the candidate. No discussions about the patients took place or were overheard and the diagnoses were not divulged. No observation of the patient, under any circumstances, was carried out by the candidate and no files or reports on the patient were read. Forty-four patients were selected and assessed by the candidate. Only thirty of the assessments were used for the statistical analysis. Fourteen assessments had to be rejected for reasons stated in section 3.5.2.

ii) Professional Team Members

Four professional team members were selected to carry out assessments on each patient assessed by the candidate. The following criteria were used :-

- (a) Psychiatric Registrar, i.e. Bachelor of Medicine undertaking training to become a psychiatrist.
- (b) Psychiatric Nurse i.e. qualified nursing sister who has undergone formal psychiatric training.
- (c) Psychiatric Social Worker i.e. qualified social worker who has undergone post-graduate training in psychiatry.
- (d) Occupational Therapist. Psychiatric training is taken for granted for all occupational therapists registered with the South African Medical and Dental Council. Only those registered with the above Council are allowed to practice in South Africa.

Age, Culture and Sex : No criteria

Experience : It was not possible to use experience as a criterion, because all psychiatric professional team members are in short supply in South Africa. Therefore only the professional training could be used as a criterion.

Method of Assessment : No criteria for the method of assessment were appropriate. In fact variations in methods of patient assessment was considered to be desirable so that the candidate could compare her method of assessment with those of the rest of the team.

Other : Selection was also made on the basis of the professional team members' willingness and time available, to participate.

3.5.1.2 Description of Procedure

Firstly, permission had to be granted by the two hospitals in which the study took place. Honorary appointments for the candidate were established in both the Johannesburg Hospital and the J.G. Strydom Hospital in order to protect both the patients and the candidate.

The Heads of the Psychiatric Departments of both hospitals were then approached. The purpose of the research was described to them and permission was granted by them for the candidate to undertake the group-work in their respective departments.

Consultation was then sought with the occupational therapists at the head of the occupational therapy departments of the respective hospitals and their cooperation in the study was obtained. A time to undertake the group-work on a regular basis, and the venue were determined. Patient selection and materials to be used were discussed.

Two monitors were appointed by the candidate. Both were selected because they were occupational therapists with at least two years of experience in working in a psychiatric occupational therapy department and who had experience in group-work and psychiatric assessment. One monitor attended all the groups in the Johannesburg Hospital and the other attended all the groups in the J.G. Strydom Hospital. As stated in section 3.3.4, the function of the monitor was to help control interfering variables such as bias in assessment, and the lack of uniformity of

technique, as well as to validate the research by being a general overseer of the research procedure.

The professional team members were then individually approached by the candidate, in order to seek their cooperation in the project and to explain the purpose of the research. The psychiatric team members who participated were the same in each hospital, namely psychiatric registrar, psychiatrically trained nurse, psychiatric social worker and occupational therapist who was working in a permanent capacity in that unit. Details of the sample selection of professional team members are in section 3.5.1.1. In most psychiatric training centres such as the two used in this study, there is a constant change-over of staff. With each change of staff, the new staff member's cooperation was again sought and the whole procedure stated above, repeated. Each member of staff participating in the research was asked to read the assessment form and in order to promote standardisation of assessment, was asked to comment on any aspect of the form that was unclear or incomprehensible.

A constant venue was then decided upon by the candidate and the occupational therapist, and the selection of the patients for the respective groups took place prior to every group session. Details of this selection are to be found in section 3.5.1.1.

The time allocated to each group was one to one-and-a-half hours. One group was held in each centre every week until forty-four patients had been assessed. Details of the techniques carried out on the groups are to be found in section 3.5.1.4 and 3.5.1.5 respectively.

An equal number of art groups and discussion groups were undertaken. It is important to this research that the composition of the groups did not remain the same because new patients had to be present in the group for the candidate to assess. However, as the treatment period for patients in these types of units is approximately three weeks, some of the group members did remain constant for the maximum of two to three groups. They had been assessed by the candidate on their first group attendance. This did assist in bringing about cohesiveness in the group, part of which had been built up in the ward itself by the interaction of patients during other activities. The occupational therapist and monitor attended each group.

There were always one or two new patients in the group for the candidate to assess and assessment took place by observation of behaviour, and non-verbal cues, and by verbal and non-verbal interaction and communication. No written notes were taken by the candidate during the group procedure and no particular emphasis placed on the patients being assessed. All group participants were treated the same.

Immediately after each group session the candidate, in the presence of the monitor, filled out the assessment form on the patients who had been selected for assessment. This procedure took approximately half an hour.

Four assessment forms were then set aside for each patient assessed, with the name and number of the patient on each. If the group had taken place in the morning items 2, 4 and 6 were deleted and if in the afternoon, items 1, 3 and 5 were deleted as explained in section 3.3.8.

The forms were taken personally to each assessor in the team who was asked to assess the patient within one week. The forms were collected exactly one week later.

At the end of the experiment, personal thanks were extended to all those staff members who had taken part in the research.

3.5.1.3 Precautions

Various precautions were observed whilst the experiment was taking place.

(a) Acutely disturbed psychiatric patients tend to become easily emotionally involved in this type of group-work. It was essential for the candidate to have professional back-up services in each unit in order to support, and be available to the patient after each group, should any adverse or intense reaction occur. The resident occupational therapist and the candidate were, on several occasions, called upon to counsel the patient after a group, to call in the support of nursing personnel, and to report the incident immediately to the registrar. The candidate never left the venue without first ensuring the support and safety of the patient. It is essential for a researcher to leave time for this type of occurrence.

(b) Any patient feeling the urgent need to leave a group whilst it was in progress, if he could not be encouraged to stay, was always followed by the occupational therapist and was never allowed to leave the group unaccompanied. Not only was the safety of the patient ensured but the situation could be dealt with outside of the group so that minimal disturbance was felt by the group members.

(iii) The purpose of the group and an overview of the candidate's research was always described to the members of the group; the fact that individual members were to be assessed could not be discussed, as this would have disturbed the experiment. Any patient was, however, given the choice of leaving the group at the beginning if they did not wish to participate.

(iv) In accordance with ethical medical procedures, all information regarding the patient and his condition remained completely confidential.

(v) Noxious art materials were avoided and sharp instruments e.g. scissors, were kept in check in the presence of acutely suicidal patients and patients with substance-use disorders. Subjects for discussion such as suicide, religion and politics, were avoided.

3.5.1.4 Assessment Procedures used by the Members of the Psychiatric Team

(i) The Psychiatric Registrar is trained to assess a psychiatrically disturbed patient by performing a structured interview with the patient individually or with other members of the family present. The patient is also observed when presented at a ward round and to a lesser extent during ward and occupational therapeutic activities. A medical examination is also undertaken. None of the registrars taking part in this study used group-work for assessment purposes.

(ii) The Psychiatrically-trained Nurse assesses the patient during an initial interview when the patient is admitted, by observing the patient during his everyday activities in the ward, such as eating and dressing, during interaction with other patients and during structured activities such as ward-climate meetings. If time allows, the nurse also observes

the patient whilst taking part in occupational therapy or when presented at a ward round.

(iii) The Psychiatric Social Worker assesses the psychiatric patient during a structured interview or counselling situation. This may be on an individual basis or with other members of the family present. Assessment also takes place during ward rounds. None of the social workers taking part in this study used group-work for assessment.

(iv) The Occupational Therapist assesses the psychiatric patient during his participation in the occupational therapy programme. After an initial interview, non-standardised concentration and memory tests are administered and the "Draw-a-Person" test is administered to test body-image. Observation of the patient during individual creative activities, group-work and in sport and recreational activities takes place. The patient, where necessary, can also be assessed in the "Activities of Daily Living" Unit, where competence in home management and self-care is determined.

3.5.1.5 Description of the Group Techniques Used in this Study

Groups are used in different ways by occupational therapists and although the variations may be slight, they could alter the effectiveness of the technique when used as an assessment procedure. It is therefore necessary to describe the techniques used in this study in order to standardise them for obtaining similar results of assessment should they be used for this purpose.

(i) Art-Groups

See Figure I.

FIGURE 1**Art-Group (Example)**

The photograph shows an art-group in progress at the Johannesburg Hospital. The candidate is seated at the far end of the group. The patients are seated on cushions with the art-materials in the centre. The discussion of the individual pictures is taking place.

Venue - A venue was chosen which was free from external stimuli such as noise and interruptions. A notice was placed on the door to indicate that a group was in progress and that no interruptions would be allowed. Enough floor space to accommodate the group members and the art materials comfortably was important, with the patients seated on the floor as in Figure 1.

Occasionally, when the patients requested it, a table and chairs were used. It should be noted that although the candidate's preference is to use the floor, some patients are extremely uncomfortable on the floor and under these circumstances a table and chairs were used. The room used was part of the occupational therapy department in both hospitals and remained constant throughout the study.

Selection of Patients - As stated in section 3.5.1.1, the resident occupational therapist selected the patients for the group, according to the criteria laid down in this study. All patients had been formally referred to occupational therapy by the Senior Psychiatrist. A minimum of five patients and a maximum of ten patients attended each group.

Time - One to one and a half hours, which were part of either the morning or afternoon occupational therapy session, were allocated to each group.

Preparation - The group area and materials were prepared in advance.

Cushions or chairs were laid out and the following variety of materials were placed in the middle of the floor or table :-

Paint brushes of different sizes

A variety of colours of ready-mixed poster paint in bottles. The primary colours of red, blue and yellow as well as black and white were always present. All other colours could be made from these.

At least four paint boxes

Oil pastels and pastels of all colours and sizes

Felt-tipped pens of all colours and sizes

Pencil crayons

Pencils, rubbers and rulers

Charcoal of all sizes

Pen, brush and Indian ink

Finger-paints in various colours

Colourful, glossy magazines

Scissors and glue (non-toxic)

Conté crayons

White newsprint and cartridge paper

Procedure - The candidate led the group with a directive technique during the introduction. During the creative process and the closure a non-directive technique was employed. At the commencement of the group the candidate introduced herself and the purpose of the research project was made clear. The purpose of the art-group was described in a manner that could be easily understood by the patients. It is extremely important to set the members of the group at ease at this stage, because the impending expectation to draw or paint, when unaccustomed to it, produces much anxiety in a patient. The description of what was expected from the patients included the fact that art was only being used as an expressive medium and that artistic talent was not required. Confidentiality of all events taking place in the group was stressed.

The members of the group were then asked to introduce themselves by stating one sentence about themselves.

A piece of paper was handed to each member of the group including the candidate and the monitor. They were asked to experiment freely with the art materials and to express the way they were feeling on the piece of

paper in front of them. They were asked to relax and let their feelings "flow" onto the paper. Any graphic expression was encouraged, including painting, drawing, writing or pasting pictures from the magazines onto the paper. Occasionally a theme such as "draw yourself as a tree" or just "draw or represent yourself", was employed.

Soft music was played in the background and it was interesting to note that as soon as the group members began to participate the anxiety-level of the group dropped markedly. Patients who found it difficult to participate were reassured and were told that they should remain within the group and just join in the discussion afterwards. This reassurance often prompted some kind of action and only on one occasion did a patient not participate graphically. When the creation of the pictures was complete, tea was served and the group reassembled to discuss their pictures. No person in the group was forced to discuss their own picture and the non-directive technique of the leader facilitated spontaneous interaction. Most members of the group were able to participate. Each one described what the picture represented, what the colours meant to them and how they felt as a member of the group. The monitor and the leader, also discussed their pictures. A short general discussion then ensued and then the closure of the group took place. During the closure, the group leader ensured that the members of the group felt comfortable and secure with their participation. Patients were encouraged to discuss their pictures with their psychiatrist and the pictures being a very personal creation of the patient they were informed that they could dispose of them or use them as they pleased.

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The group members were not asked to tidy up but were asked to leave the group without discussing any of the group interaction with other patients.

The candidate, in the presence of the monitor, filled out the assessment forms on the one or two patients who were being observed for assessment purposes.

(II) Discussion Groups

See Figure II, page 66.

Venue - A venue was chosen which was comfortable and free from external stimuli such as noise and interruptions. A notice was placed on the door to indicate that the group was in progress and that no interruptions were to be made. At the J.G. Strydom Hospital the ward lounge was used as a venue and at the Johannesburg Hospital the group room which had been used for the art groups was used. In both cases the venue remained constant.

Selection of Patient - The selection of patients took place as stated in section 3.5.1.1. All patients had been specifically referred to occupational therapy.

Time - The average time taken for the discussion group was one hour. The group took place either in the morning or afternoon of the occupational therapy programme.

Preparation - The room was prepared in advance. Either cushions were placed on the floor or comfortable chairs placed in a ring, depending on the preference of the patients. Their comfort was of prime importance.

Procedure - A directive leadership technique was employed at the

outset of the group and at intervals during the discussion. This was to keep the members of the group to the topic under discussion. A non-directive, permissive leadership technique was used for the remainder of the group in order to promote spontaneous interaction. When the group members had assembled, after introducing herself, the candidate described the purpose of her research and then the purpose of a discussion group. The anxiety level in these groups was not as high as that of the art group, yet it did exist. Allowing the group members to introduce themselves in one sentence did help to lower this anxiety. The confidentiality of the group was stressed by the leader.

A topic for discussion was then called for from the group. Usually various topics were introduced and the group made a decision as to which one would be discussed. The patient who presented the topic was asked to introduce it to the group. When a topic was not forthcoming from the group, the candidate intervened with a suitable topic. Subjects for discussion ranged from concrete to abstract, but the subjects of religion, politics and suicide were avoided. The candidate reintroduced the subject at suitable intervals and when as many patients as possible had been drawn into the discussion a summary was made. The patient who introduced the topic was always given the last word on the subject and was thanked for his participation.

Group members were then asked to share their feelings about the group and after insuring that each member felt comfortable about their participation in the group, they were encouraged not to continue the discussion outside of the group and the group broke up.

The candidate, in the presence of the monitor, then set about filling out the assessment forms on those patients who were being observed for assessment purposes.

FIGURE II

Discussion Group (Example)



The above discussion group is taking place at the Johannesburg Hospital. The candidate is facing the camera. Six patients are present, four are clearly seen and two are obscured on the right and left-hand side of the photograph. The group is in the initiation stage of the introduction.

3.5.2 Data Analysis

In order to analyse the data statistically, thirty complete sets of assessments were required.

Forty-four patients were assessed. Fourteen sets of patient assessments had to be discarded for the following reasons :-

- (i) Five sets of assessments by the other members of the psychiatric team who were participating in the study, were not completed within one week of the candidate's assessment. The reason for this was usually unforeseen circumstances such as illness, or the patient being discharged. One must also take into consideration the shortage of professional staff, the heavy patient loads and the difficulties in finding time to participate in the study.
- (ii) On three occasions the full complement of five assessments could not be obtained because one of the evaluators did not come into contact with the patient. This was very often the social worker who does not, as normal procedure, always interview every patient in the ward. Occasionally one of the other team members changed to another area during the week and the assessment could not be completed.
- (iii) Incorrect completion of the assessment form accounted for the discarding of two sets of assessments.
- (iv) Four sets of assessments were discarded to give an equal number of patients assessed during the art groups and during the discussion groups. The final total of thirty sets of assessments included fifteen who had been assessed during the art groups and fifteen who had been assessed during the discussion groups.

For each of the thirty patients five separate assessment forms had been filled out. For the sake of this study the members of the team (the evaluators) were given a letter as follows :-

- A - Psychiatric Registrar
- B - Psychiatric Nurse
- C - Psychiatric Social Worker
- D - Resident Occupational Therapist
- E - Candidate

One form (see Table I) was used to correlate the data from the five assessments of each patient. The patient's name and the hospital where he was being treated was recorded at the top of the form. Section I, II, III, IV and V in the left-hand column correspond to the sections in the Assessment Form (see Appendix A), namely Affect, Thought, Social Behaviour, Communication and General. Numbers 1 - 52 are each of the fifty-two characteristics named on the Assessment Form. One column is given to each evaluator and the letter designated to that evaluator is placed at the head of the column.

Table II indicates how the data were transferred from the five assessment forms onto Table I. If an evaluator found a characteristic in a patient to be present, a (✓) was placed in the appropriate column. (Note: the example presented has only ten characteristics.)

Name:

Hospital:

		Evaluator						
		A	B	C	D	E		
	1							
	2							
	3							
	4							
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SEC. I	9							
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SEC. II	21							
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SEC. III	29							
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	39							
SEC. IV	40							
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	45							
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	47							
	48							
SEC. V	49							
	50							
	51							
	52							
SEC. I	TOTAL							
SEC. II	TOTAL							
SEC. III	TOTAL							
SEC. IV	TOTAL							
SEC. V	TOTAL							
GRAND TOTAL								

TABLE II
INDICATING THE PRESENCE (✓) OF CERTAIN CHARACTERISTICS
ACCORDING TO FIVE EVALUATORS

CHARACTERISTIC	EVALUATOR				
	A	B	C	D	E
1	✓	✓		✓	✓
2	✓	✓	✓	✓	✓
3		✓			✓
4	✓		✓	✓	
5					
6	✓	✓	✓	✓	✓
7		✓		✓	✓
8	✓		✓		
9	✓				
10	✓	✓	✓	✓	✓

TABLE II
INDICATING THE PRESENCE (✓) OF CERTAIN CHARACTERISTICS
ACCORDING TO FIVE EVALUATORS

CHARACTERISTIC	EVALUATOR				
	A	B	C	D	E
1	✓	✓		✓	✓
2	✓	✓	✓	✓	✓
3		✓			✓
4	✓		✓	✓	
5					
6	✓	✓	✓	✓	✓
7		✓		✓	✓
8	✓		✓		
9	✓				
10	✓	✓	✓	✓	✓

Table III shows how a numerical weighting was applied to each evaluation. The weighting denoted the level of agreement between the evaluators. If all agreed that a characteristic was present, five points were given to that assessment item. If four agreed that a characteristic was present, the value of four was given to those in agreement and only one to the evaluator that disagreed. A total of scores was made at the bottom of each column for each evaluator and a mean calculated. (Note again that the example in Table III only demonstrates the calculations with ten characteristics.)

TABLE III
NUMERICAL WEIGHTING OF EACH EVALUATION

CHARACTERISTIC	EVALUATOR				
	A	B	C	D	E
1	√4	√4	1	√4	√4
2	√5	√5	√5	√5	√5
3	3	√2	3	3	√2
4	√3	2	√3	√3	2
5	5	5	5	5	5
6	√5	√5	√5	√5	√5
7	2	√3	2	√3	√3
8	√2	3	√2	3	3
9	√1	4	4	4	4
10	√5	√5	√5	√5	√5
TOTAL	35	38	35	40	38
MEAN	3,5	3,5	3,5	4,0	3,5

Table I, the actual form used for the calculations, allowed for the calculations of the totals for each section of assessment at the base of each column, a grand total and a mean. The mean was used in the statistical analysis of data.

Professor H. H. Lemmer of the Institute of Biostatistics of the Medical Research Council analysed the data by using the non-parametric Friedman Test; (Siegel 1956), the Hotelling T^2 Test and the individual t-test (Kshirsagar 1976). The results were calculated by computer.

(Note : Appendix B gives the results of the statistical analysis of the first ten assessments which was undertaken by Dr. S.G. Reinach of the Institute of Biostatistics of the Medical Research Council for a public lecture. This analysis gave a good indication of the direction of the study which continued in the same manner until a full sample of thirty patients was complete. As the results of Appendix B do not differ from the final results they will be discussed in Section 3.6)

3.6 Results

3.6.1 Results of the statistical analysis of data by Professor H. H. Lemmer, 29th April 1983.

Project : Assessment of patients by five evaluators

The first analysis has been performed on the mean score allocated to a patient by each evaluator. Due to the nature of the scores, the non-parametric Friedman test has been applied to each of the two groups to test the hypothesis that the evaluators do not differ.

Group 1 : Art Group

Evaluator Rank Sum

A 31,5

B 51,5

C 43,5

D 54,0

E 44,5

Friedman test statistic = 8,21

p - value = 0,0841

Group 2 : Discussion Group

Evaluator Rank Sum

A 37,5

B 52,5

C 38,5

D 53,0

E 45,5

Friedman test statistic = 6,64

p - value = 0,1662

In both cases the evaluators do not differ significantly.

In the second analysis the Hotelling T^2 test and individual t-tests have been applied on the total scores to test whether there was a difference between the art and discussion groups. The overall test gave $T^2 = 5,9066$ with p-value 0,4320 which is not significant. Thus the art and discussion groups do not differ.

If we look at the evaluators individually, very similar results have been obtained. In the case of evaluator A, a p-value = 0,396 has been obtained, but since 5 simultaneous t-tests are involved, when testing at the 5% level this p-value should be compared with $0,05/5=0,01$, so that it is not significant. The results are given in the following table :-

TABLE IV

Values of t-test statistics

Evaluator	t	p-value
A	-2,16	0,0396
B	-1,88	0,0686
C	-0,41	0,6846
D	-1,35	0,1877
E	-1,58	0,1271

3.6.2 Analysis of the Results

(i) The non-parametric Friedman test which has been applied to the data of both the art and the discussion groups to test the hypothesis reveals that the evaluators do not differ significantly in assessment. There is no significant difference between the data representing the candidate's assessment of a patient during either the art or the discussion group, and the data representing the assessments made by the other members of the psychiatric team.

(ii) In the second analysis the Hotelling T^2 test and the individual t-test have been applied to the total score to test whether any difference existed between the results of the assessments of the fifteen patients of the art groups and the fifteen patients of the discussion groups. The analysis revealed that there was no significant difference between the results of the two different types of groups.

(iii) Not only were the data relating to the difference between the candidate's assessment and the team as a whole analysed, but also the individual results of the evaluators individually. Again no significant difference is apparent.

(iv) It is important to note that the results of (iii) also indicate that there is no significant difference between the assessments made by the resident occupational therapist and those made by the candidate.

3.7 Conclusions

(i) The fact that no significant difference is evident between the candidate's assessment of psychiatric patients and those made by the other members of the psychiatric team indicates that the candidate's

assessment compares favourably with the other assessments and is therefore a reliable contribution to the team evaluation of a patient.

Taking into consideration the short period, namely one or one and a half hours in which the candidate's assessment took place, and the relatively longer period, namely a week, in which the other evaluators undertook their assessment, it would appear that the shorter period with the group was sufficient time in which to make a reliable assessment. More significant is the fact that the results show that the procedures used for assessment, namely art and discussion groups, are an effective and reliable method for the assessment of the psychiatric patient. It would also appear that an assessment of a patient during group-work is as reliable as an assessment made of a patient during individual counselling and observation. One of the obvious conclusions to this statement is that group-work is a quick and efficient way of assessing more than one patient at a time. It should, however, be noted that this conclusion refers only to art and discussion groups specifically.

(ii) The lack of significant difference between the assessments made by the candidate during the art groups and the team, and between those made by the candidate during discussion groups and the team indicates that both these techniques of occupational group therapy are effective as assessment tools. In other words, the use of both verbal and non-verbal communication in a group, is equally effective for assessment purposes. The use of creative media on one hand and discussion on the other also made no difference to the results.

(iii) The results of the individual t-tests and the non-parametric Friedman test shows that no significant difference exists between the assessments made by the evaluators individually. This result indicates that there is a consistency of assessment in the psychiatric team, and that the interrater reliability of both teams used in the study is high. One can conclude from this result that a parallel standard of psychiatric training of all professional people included in this study exists.

(iv) The results of the individual t-tests also indicates that the assessments made by the candidate (an occupational therapist) and those made by the resident occupational therapist do not differ significantly. One can conclude from this result that occupational therapy group-work is as effective in assessing a psychiatric patient as a whole week of varied activities.

3.8 Discussion

The major result of the statistical analysis of data has proved the hypothesis to be correct, namely, that the assessment of a psychiatric patient by the occupational therapist during group-work does not differ significantly from those assessments made by other professional members of the psychiatric team over a longer period. The statement based on this hypothesis that the assessment made by the occupational therapist is a reliable contribution to the team evaluation of the patient also holds true. In the same way the results of the analysis of data have also proved the reliability of the assessment made by each individual member of the psychiatric team who participated.

In addition to testing the hypothesis and achieving positive results, other important issues have come to light during this study. One of the interesting results is the lack of a significant difference in the results with the use of either art or discussion groups for the assessment of psychiatric patients. As has been previously mentioned, these two types of group-work are frequently used in psychiatric occupational therapy departments and it is important to note that no difference was found in the effectiveness of the techniques for assessment purposes. One is tempted to consider the inclusion of other types of occupational group therapy such as music groups, concentration groups and psychodrama within the same framework, but of course further research would have to be done to prove that these techniques are equally effective for assessment.

Another interesting result of the research, although it has not been stated as a major aim, is that the interrater reliability in the psychiatric team is high. This result has a broader significance than the aims of this research and has great significance as regards the consistency of treatment approach in both psychiatric teams used in the study. It is also an important consideration to be borne in mind in the training of occupational therapy students. Interdisciplinary teamwork in psychiatry, as in most areas of medicine, has great value for the patient, as well as providing an important support system for staff and an opportunity for ideas and treatment principles to be discussed. The occupational therapist's involvement in the team has already been mentioned. However, the results of the major study do reinforce the

effectiveness of the occupational therapists contribution to the team, which in this case is the assessment of a patient leading to diagnosis and rational treatment. This is seen as a very important outcome of the research.

For some time the candidate has been under the impression that art-groups and discussion groups are quick and efficient methods of assessing psychiatric patients in occupational therapy, just as efficient in fact, as a whole week of various other types of activities. The analysis of the individual data of the assessors has certainly proved this point, as no significant difference is apparent between the two occupational therapy assessments, namely those of the candidate's and those of the resident occupational therapist. However, it should be pointed out that the actual group-work itself should comply with the description made in this study, for similar results to be achieved. Major alterations to the structuring of the group may produce a less effective milieu for assessment.

Various factors relating to the assessments made by the other team members are relevant to this study. It is not known, nor was it a consideration at the outset, how many times the other evaluators came into contact with the patient they were asked to assess, during the period of the week after the candidate's assessment had taken place. It is possible that the psychiatric nursing sister and the resident occupational therapist had the most contact with the patient. Although no significant difference is apparent between their assessments, and because we do not know how much contact was made, it would not be possible to deduce the effectiveness of their assessment methods from this study. The only comparison that

can be made is between the candidate's assessments and those of the resident occupational therapist as already described, in which regard more facts are known about the contact with the patient in this case by the two occupational therapists.

The differing levels of expertise of both the candidate and the various members of the psychiatric team has been mentioned as an interfering variable in this study. The only criterion for the selection of staff was basic professional training. It would have been impossible to find participants for the study with identical experience. One must also take into account personal variables such as special abilities and personality traits which are present in the members of the team. Had the results of the experiment shown a significant difference between the evaluators, these factors would have had to be taken into consideration and a further study undertaken to try and eliminate these variables. It is, however, important to note that the results of this study indicate that levels of expertise and personality traits on the part of the evaluators do not influence the interrater reliability. This is a sound indication that the level of professional training is of prime importance in the reliable assessment of patients. There was, however, no control group to prove this point.

CHAPTER IV

4.1 General Conclusions

In order to determine how reliable occupational group-therapy is as an assessment procedure with acutely disturbed, adult psychiatric patients, two studies were undertaken, namely the preliminary study in Chapter II and the major study in Chapter III. The results from these two studies form the basis of the following conclusions :-

(i) Fourteen aspects of psychiatric assessment, derived from the Likert Attitude Scale, were chosen by ten psychiatrists who took part in the experiment. These aspects of assessment are considered by them to be valuable or very valuable as a contribution to the team evaluation of a patient, leading to the formulation of a diagnosis. The psychiatrist is the leader of the psychiatric team.

The result of the preliminary study was the most important factor in drawing up the assessment form which was used to standardise assessment in the Major Study. See Appendix A.

(ii) The occupational group therapy short-term assessment of psychiatric patients made by the candidate, compares favourably with those assessments made by the other members of the psychiatric team over a longer period. The statistical analysis of the data obtained in the major study indicates that no significant difference is apparent between the assessments made by the candidate and those made by the psychiatric registrar, the psychiatric nurse, the psychiatric social worker and the resident occupational therapist. The conclusions indicate that the candidate's assessment is

therefore a reliable contribution to the team evaluation of a patient.

(iii) The statistical analysis of data in the major study also indicates that no significant difference occurred in the assessments made by the candidate during group-work and those made by the resident occupational therapist whilst assessing the same patients during their various other activities. The conclusion drawn from this result is that occupational group therapy is an effective brief and reliable method of assessing the acutely disturbed, adult psychiatric patient.

(iv) The lack of significant difference between the candidate's group assessments and the methods of assessment used by the other evaluators indicates that the use of art and discussion groups specifically are effective and reliable tools of assessment. The statistical analysis of data also revealed that no significant difference occurred between the art and the discussion groups as separate techniques. One must conclude from this result that both methods of group-work are equally effective for assessment purposes.

(v) The interrater reliability between the members of the two psychiatric teams who participated in the study was found to be high. This was a conclusion which was made from the results of the statistical analysis of data in which no significant difference was found in the assessments of the evaluators individually. Their assessment compared favourably one with another and their reliability of assessment was thereby determined.

4.2 Discussion

Feder and Feder (1981₀) state that "Unless theoretical formulations are actually tested in practice under controlled conditions, there is no

way of knowing what actually works." (p. 53) The theoretical formulation or hypothesis of this study has been tested in practice under controlled conditions and has proven to be correct. We know, therefore, that occupational group therapy is a reliable manner in which to assess the acutely disturbed, adult psychiatric patient; we know now, that it actually works.

Although many other important factors have come to light as a result of testing the theory, the main reason for undertaking this research was to prove the reliability of art and discussion groups used as assessment procedures by occupational therapists.

Most occupational therapists working in any field of practice are creative people but occupational therapists working in the field of psychiatry are generally known to be particularly adept in the use of creative techniques such as art, music, drama, pottery, etc. It is often this kind of occupational therapist to whom group-work comes naturally. It is important to note that in most psychiatric occupational therapy departments throughout the country much group-work of many different kinds takes place varying from structured activity groups in which painting, découpage, batiks etc. are encouraged, to the more interactional groups, such as newspaper, concentration and discussion groups, to the socio-emotional groups, such as art and music groups and psychodrama.

Feder and Feder (1981_d) state that "practitioners in the arts therapies themselves have been slow in developing programmes of self-evaluation or of investigation of the outcome of treatment." (p. 53) This is

particularly true of occupational therapists in the field of psychiatry. The reasons for this seem to be twofold. Firstly, as stated in the introduction, most occupational therapists working in the psychiatric field have to treat large numbers of patients for whom a whole day's programme of activities is planned. It is difficult to find time to do research. No research posts are yet available in psychiatric hospitals for occupational therapists, and as a consequence of these circumstances very little research is undertaken. The second factor is that much of the psychiatric occupational therapist's creative energy is channelled into the treatment of patients and very little into research. There is, however, a "wind-of-change" occurring. There is evidence to believe that many more occupational therapists are beginning to record data and are becoming very aware of the urgent need to do research.

Group-work is not by any means the only type of technique into which research is required. All tests used in psychiatric occupational therapy need to be standardised. No reliable standardised tests are yet available for concentration, memory, home-management, self-care, etc., although a start has been made by the occupational therapy departments of the major universities in South Africa. Under-graduate project studies have been undertaken by final year students whose research could be the basis of, or be used as pilot studies, for more intensive research on various aspects of treatment and assessment techniques in occupational therapy. These projects show a determined effort on the part of the training centres to introduce research methods to occupational therapy students and to encourage an interest in carrying out research in any clinical situation. Morcellin (1982_a) says :-

"then occupational therapists, like any other discipline must maintain the highest standards of professionalism. To do so, however, occupational therapists must be clear about the particular clinical contribution they are making in psychiatry".
(p. 110)

What is it that makes art and discussion groups such an effective tool for the assessment of the acutely ill, adult psychiatric patient?

Reasons for this could be as follows :-

(i) The acutely ill psychiatric patient sometimes shows florid symptoms.

It is correct to state that first impressions of such a patient could be gained in almost any situation where he is being observed. However, group observations as opposed to individual contact observations have the advantage of seeing the patient interact with others. This could be a vital factor in determining the functional problems of the patient which may be interpersonal relationship difficulties and social dysfunction. Other factors such as anxiety and stress are often experienced by a group member and it is often important to note how a patient reacts in the face of stressful situations.

The acutely ill psychiatric patient who does not exhibit florid symptoms and whose psychopathology is somewhat hidden, is also, in the candidate's opinion, better observed and assessed in a group situation. Often the patient's inability to function adequately in the group, in terms of fulfilling interactional demands or the demands made by carrying out an activity, uncovers the underlying psychopathology.

(ii) One of the most important points in the use of group-work for assessment, from the occupational therapy point of view, is the use of activities in the assessment group. This is a unique feature of

occupational group therapy. It should be noted that this study has not examined the use of group-work in which a structured activity is not included because these groups do not fall within the scope of occupational therapy in South Africa. There is no proof, therefore, that group-work, using activities such as discussion and art, is more effective for assessment purposes than counselling or psychotherapeutic group-work.

However, occupational therapists over the years have analysed the activities they are using for treatment purposes in terms of how much concentration or memory is required to carry out the activity, the interaction the activity demands, the emotional response that is stimulated by the activity, the degree of organisation of thought required to carry out the steps of the activity, etc. As a result of this analysis the occupational therapist is able to use activities either individually or in groups which she knows will elicit a particular response. The most interesting responses that an activity used in group-work elicits are the functional responses which include the patient's ability to carry out the activity, whether verbal or non-verbal, the ability to relate to other people, the patient's level of spontaneity and his social behaviour. The observation and assessment of a patient who is involved in an activity in a group such as art and discussion is therefore very much facilitated. A quote from Morcellin (1962) is appropriate here :-

"The occupational therapist uses verbal and non-verbal methods and cues, structures the environment in a way which optimises responses and continually evaluates the needs of the patients to increase or decrease the demands the activity makes on the individual." (p.113)

The use of structured discussion in occupational group-therapy appears to be widely accepted and unchallenged as long as it does not encroach on the psychotherapeutic domain. Very little is written about it.

Art therapy, projective art, etc. is, however, fairly well documented and many professionals, including occupational therapists, and non-professional people are using these techniques. Outside of South Africa professionals called art therapists, creative therapists and expressive therapists, are trained exclusively in the therapeutic use of art both individually and in groups. The World Federation of Occupational Therapists, at a meeting in South Africa in 1981, expressed great concern that these therapists tended to work in isolation with their treatment and that the service to the patient was partly fragmented by this practice. This situation has not occurred to any degree at present, but it should be noted that if a supplementary register is created by the South African Medical and Dental Council for these single-medium therapists and they can then legally carry out their practice in South Africa, it is of utmost importance that they work within the team framework. The conclusions of this study clearly indicate the important contribution that the psychiatrically-trained professional person using art as a medium in a group, can contribute. The occupational therapist will always continue to use the art-group as a therapeutic technique as it falls well within the scope of occupational therapy, and it is hoped that legislation will firmly encourage the art-therapist to work in close cooperation with the occupational therapist and the psychiatric team. It is in this way that the patient would receive maximum benefit. Cartwright and Zander (1988_a) in their work on group

dynamics, reinforce the importance of the different disciplines working together. They describe how the different people studying groups from the different disciplines have special vocabularies of their own particular disciplines, as well as certain assumptions about the degrees of importance of the various aspects of groups. It is the candidate's belief that the standardisation of terminology and procedures in the dynamic use of art as a therapeutic medium can only be achieved if a true, working together team-work is achieved. If this is achieved then the following statement by Robbins (1980_d) may become a reality, "Finding creative ways to see the productive expression of pathology can often change defeat into victory." (p. 35)

(iii) One of the important reasons why group-work is an effective method of assessment is that during group-work the patient is seen as a whole rather than a set of symptoms. The "totality concept" is a basic premise in occupational therapy and is one of the concepts on which all treatment is based. During assessment and treatment every aspect of the patient's life is taken into consideration, i.e. his social, work and recreational domains. Occupational group-therapy definitely incorporates this approach in that many facets of a patient's life come to the fore. Often during art and discussion groups a patient is encouraged to talk about, or demonstrate by using art materials, different aspects of his life. This may include his leisure time, his work, his family relationships etc. One must recognise the fact that during individual counselling these facts may also come to light but it may take longer.

(iv) An important practical aspect of using group-work for assessment is that more than one patient can be assessed at the same time. This is an important consideration when large numbers of patients are treated at one time.

(v) The results of the comparison between the assessments made by the candidate and those made by the resident occupational therapist indicate that occupational group therapy is a quick, efficient and reliable method of assessing the psychiatric patient. It is the candidate's opinion that this type of short-term group work incorporates the use of first impressions of a patient, which are often significant. As is well known, first impressions of a person are later clouded by many other interactions in different situations. This fact could be one of the reasons why the assessment groups described in this study are so successful. This interesting subject could be the basis of another research project.

The advantages of using group-work for assessment have been discussed at length, but it should be noted that there are definite occasions when the use of group-work is inappropriate. Patients who are immobilised by depression, have an uncontrollably high level of anxiety, have phobias related to a small group of people or a confined place, are difficult to assess in a group. Patients who are floridly psychotic are uncontrollable in a group situation and disturb the other group members. However, the occupational therapist must use her discretion in the use of the appropriate assessment technique and may have to resort to individual assessment using an interview and a structured activity.

One of the most rewarding aspects of this study in the case of both the preliminary study and the major study, has been the cooperation and assistance of the members of the multi-disciplinary team. The candidate's contact with psychiatrists in the preliminary study brought to light the psychiatrist's interest in research being carried out in occupational therapy as well as the desire on everyone's part to maintain a high level of team-work in psychiatry. In the major study cooperation from all the team members was maximal and their interest in the project expressed. Team-work in psychiatry is of utmost importance, not only (as discussed in section 3.8) does it provide a support system for the staff who, particularly in psychiatry, are often dealing with difficult patients and their personal issues, but it also encourages the pooling of valuable information. As can be seen from this study, the information gained from the assessments of a patient in various situations contributes significantly to the formulation of a diagnosis for that patient which in turn determines the treatment strategy. Members of a cohesive team discuss treatment strategies which may include such methods as the use of a behavioural approach, the setting of certain limits and the contra-indications in treatment.

The interrater reliability which is evident as a conclusion of this study indicates that in both the psychiatric teams used in the study, the ability of the team members to assess the psychiatric patient was consistent. Interrater reliability is not only related to the professional training of the team members but is also a factor which is built up by the frequent interaction of the team members over a period of time.

The dynamics of group-work also operate in this team. The members of the team, by means of group pressure, conform to the norms of the group by using similar terminology and techniques of assessment and by keeping up with the most recent trends in psychiatry. Learning on an on-going basis occurs and the whole interaction of the team ensures a consistent approach to the patient. The training of professional personnel to work in the psychiatric team should also be mentioned. The conclusions of the major study state that the ability of the team members who participated in the study, to assess the psychiatric patient according to various criteria was consistent. Therefore training in psychiatry, particularly in the Transvaal, be it basic training or post-graduate training, within the team leads to development of a consistent standard. This result is particularly relevant to the training of occupational therapy students whose psychiatric syllabus is always being updated and reviewed. The psychiatric syllabus must be of an adequate standard.

This study has also clearly shown that a team-member's specific ability to assess a patient at his level of experience has not interfered with the results. This is a very important result of the experiment in that it is clear that emphasis must be placed on basic knowledge and team learning of psychiatry for the professional members of the psychiatric team.

One of the objectives of this study was to discuss priorities in occupational therapy training as a result of this study. Since the assessment of the acutely disturbed adult psychiatric patient during art and discussion groups has proved to be effective and because this aspect

of the occupational therapist's contribution to the psychiatric team is of utmost importance, the following aspects of training of the occupational therapy student must be reinforced :-

- (i) Comprehensive psychiatric theory, including all the latest theories and trends in psychiatry, must be taught. Up-to-date treatment methods and details of medication must be included.
- (ii) Training in assessment techniques in psychiatric occupational therapy which includes the specific use of activity designed to elicit a particular response in a patient is a teaching priority. As already stated in this study, standardized methods of assessment are few, but students should be trained to use their individual activities to test the patient's functioning in all the spheres of life. Group-work appears to have special significance for assessment as well as being an effective treatment tool.

In any event it is clear that adequate training in group techniques is an all-important requirement for occupational therapy students. This training should include the teaching of group dynamics and group leadership, and experience in leading groups should take place under controlled conditions with supervision. Occupational therapists recognise today the importance of a comprehensive training in group-work, a technique used not only in the treatment of the psychiatrically disabled but in the field of the physically disabled as well.

- (iii) Training in the use of activities in groups is also a priority. Students must acquire a knowledge of the various media such as art, music, poetry, movement, drama and discussion, and then learn how to apply the activity to the group situation.

(iv) Students must also be made aware of team interaction in psychiatry. An understanding of the different roles of the members of the team must be gained as well as a knowledge of team etiquette and ethical issues. The student must also have the opportunity during training, to be part of a team to learn to contribute to it in an effective way. Occupational therapy students must learn to report on their patients in a concise, professional manner using standardised terminology and making firm and constructive comments as to the handling of the patient in treatment. It must be made clear how valuable this contribution is.

It should be made clear that most of the above training requirements are already standard practice in South Africa and are included in the Minimal Standards of Training laid down by the South African Medical and Dental Council in 1978. It has, however, been interesting, in reviewing a set of requirements in student training to comply with the needs of this study, to find that most criteria are already included in the basic training of occupational therapy students.

The last objective of this study was to validate the role of the occupational therapist in the use of group techniques for assessment. This objective has only been partly achieved because only the use of discussion and art groups were used in the study. One could conclude, however, that if the basic training in occupational therapy is as comprehensive as stated above, then the therapist should be equally competent in carrying out any type of occupational group therapy including art and discussion groups. As already stated, it is not

known how effective other methods of occupational group therapy will be in assessment. However, this study has validated the role of the occupational therapist in the use for assessment of two frequently used techniques, namely art and discussion groups.

4.3 Finale

From birth to death, groups assume importance as part of the social system and become an integral part of our lives. We are born into a family structure which has a marked influence on our personalities. We are influenced by peer groups and other social groups who help us to mould our behaviour. We are supported by working and caring groups of various kinds throughout life.

The pushes and pulls within any group that make us conform, and the conflicts that arise, as well as the motivation gained from the group to participate in life, are significant results of belonging to a group.

If a group is carefully structured and led by a sound, professionally trained person in a treatment milieu, it follows that treatment should be effective for the majority of patients in that group.

In agreement with Licht (1948) the candidate believes that, in the field of psychiatry, occupational therapy finds its oldest and widest acceptance and that there is no substitute for the unique contribution of the occupational therapist to the multi-disciplinary psychiatric team.

"Occupational Therapy, in spite of the continuous questioning about its theoretical foundations and effectiveness owes its resilience to the simple fact that it has always emphasised quality of life issues and the unique characteristics of patients."
(Mocellin 1982) (p. 115)

QUESTIONNAIRE
ASSESSMENT OF PATIENT

RBC/2

□

is emotionally labile i.e. cries, laughs etc. easily with slightest stimulation

17

has poor expression of emotions i.e. has inappropriate emotional expression or is unable to express emotions

18

THOUGHT

The patient :—

has a disturbance of the form of thought
i.e. thought is not logical or realistic

19

has a disturbance in the structure and speed of associations

20

has a disturbance of thought content e.g. delusions,
preoccupations, hypochondriacal ideas, obsessions or phobias

21

has a disturbance of concept formation i.e. does not understand basic concepts
(form of objects), elementary concepts (involves understanding
elementary function of objects), composite concepts (the
combining of basic and elementary concepts) or abstract
concepts (multidimensional concepts which do not have
concrete symbols)

22

has suicidal thoughts

23

SOCIAL BEHAVIOUR

The patient's behaviour is :—

detached

24

withdrawn

25

passively negative

26

aggressively negative

27

aggressive i.e. shows physical or verbal aggression

28

disruptive

29

agitated

30

dominant

31

demanding

32

bizarre i.e. unusual or strange

33

dependent on others

34

compliant i.e. carries out every demand or request

35

COMMUNICATION**The patient :—**

can initiate communication
i.e. approaches you or another person first

36

cannot initiate communication

37

communicates well on a verbal level

38

communicates poorly on a verbal level

39

can maintain communication
i.e. keeps in communication with you
over a period

40

cannot maintain communication

41

uses non-verbal communication in the form of
facial expression

42

body language

43

physical closeness

44

graphic means

45

GENERAL**The patient :—**

has suicidal tendencies

46

is spontaneous

47

lacks spontaneity

48

has insight into his relationship with others
i.e. can judge type of relationship he makes with others

49

has no insight into his relationships with others

50

has insight into his condition
i.e. has an understanding as to the nature of his illness

51

has no insight into his condition

52

This questionnaire belongs to :—
Rosemary Crouch
lecturer in the Department of Occupational Therapy
University of the Witwatersrand

**ANALYSIS OF VARIANCE TABLE FOR A TWO-WAY LAYOUT
WITH ONE ELEMENT PER CELL**

SOURCE	DEGREES OF FREEDOM	SUM OF SQUARES	MEAN SQUARES (VARIANCE)	F	PROBABILITY
PATIENTS	9	2,285,632	0,253959	16,81	0,0001
RATERS	4	0,097112	0,024278	1,61	0,1937
ERROR	36	0,543928	0,015109		
TOTAL	49	2,926672			

AVERAGE SCORES OBTAINED BY THE VARIOUS RATERS

A	B	C	D	E
3,955	4,029	4,034	4,091	4,049

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